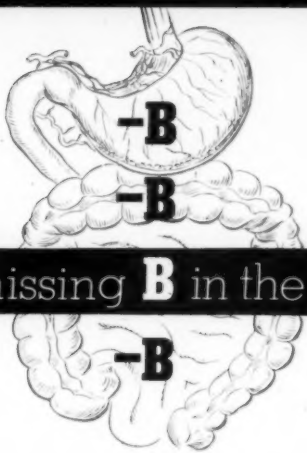
June

Medical Economics

25TH YEAR OF PUBLICATION

• How the AMA House of Delegates Works • Page 55



the missing **B** in the Bowel

The close association of gastro-intestinal disorders and frank vitamin B deficiencies has suggested B complex therapy in treating such disorders. Chesley and co-workers,* reporting 72.5% satisfactory results with this therapy, state that: "... vitamin B complex offers more to many patients . . . than any of the regimes of careful dieting, antispasmodics, sedation, etc., now in common use."

more effective B therapy based on liver

The Special Liver Fraction used as the base of Beta-Concemin provides additional B complex factors not available in synthetic mixtures alone—as evidenced by the better weight, development and survival of laboratory animals to whose diet this Special Liver Fraction has been added.

potencies increased

Now the clinically established B vitamins in the Beta-Concemin formula have been strengthened and rebalanced for increased effectiveness—while the addition of choline reflects newer work on the value of this factor in liver conditions. ALL AT NO INCREASE IN PRESCRIPTION COST.

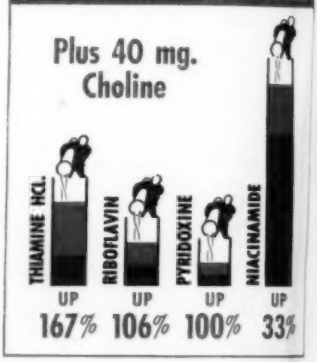
ELIXIR—4-oz., 12-oz., and gallons
TABLETS—bottles of 100 and 1000
CAPSULES with Ferrous Sulfate—bottles of 100 and 1000

"Beta-Concemin" ®

BETA-CONCEMIN

The *DIFFERENT* Vitamin B Complex

FORTIFIED FORMULA



Each fluidounce of Elixir Beta-Concemin now contains 32 mg. Thiamine Hydrochloride, 16 mg. Riboflavin, 8 mg. Pyridoxine Hydrochloride, 80 mg. Niacinamide, 40 mg. Choline Citrate and 4 Gm. Special Liver Fraction. Capsule and tablet potencies increased in same ratio.

*Am. J. Dig. Dis. 7: 24-27 (1940)

MERRELL 1828

THE WM. S. MERRELL COMPANY • CINCINNATI, U.S.A.

Medical Economics

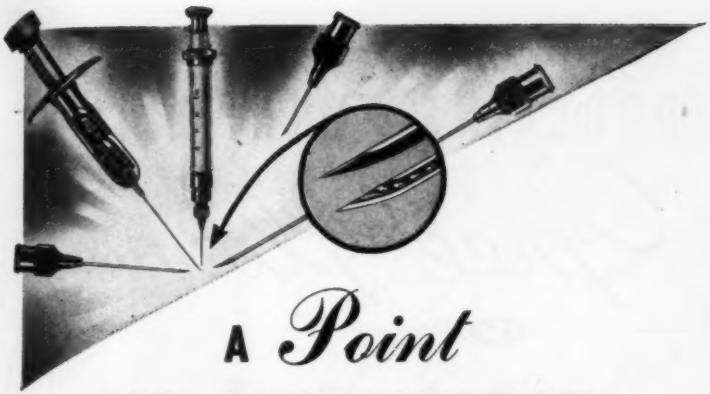
* * * *June 1948* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Cont.*]

DEPARTMENTS

Editor-in-Chief, H. Sheridan Baketel, M.D. *Editor, William Alan Richardson. Associate Editors, Edmund R. Beckwith, Jr. and R. Cragin Lewis. Publisher, Lansing Chapman. Business Manager, W. L. Chapman, Jr. Sales Manager, R. M. Smith.* ☆ *Copyright 1948, Medical Economics, Inc., Rutherford, N.J. 25c a copy, $3 a year (Canada and foreign, $3.50). Circulation: 135,000 physicians, residents, and internes.* ☆ PICTURE CREDITS *(left to right, top to bottom): Cover, Garraway; 71, U.S. Public Health Service; 66, John Crivelli; 63, Pix; 56, 57, Joseph Merante; 48, 49, 50, Maynard L. Parker.*



A *Point* FOR CONSIDERATION

It's the B-D HUBER POINT – with lateral opening and closed bevel. Now available on Yale B-D Lok-Needles – at the same price as Regular Point.

• MANY PHYSICIANS HAVE USED Yale B-D Lok-Needles with HUBER POINT with excellent results. A glance at the design of the HUBER POINT shows why it reduces pain . . . trauma . . . and seepage. The lateral opening is out of the path of penetration . . . not in position to punch out tissue plugs. The sharp B-D point, followed by a smooth closed bevel, minimizes tissue disturbance and pain. It simply slits skin and tissue, the elasticity of which helps to control seepage.

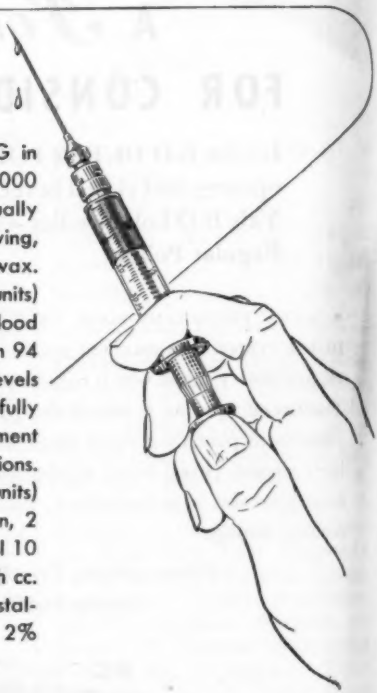
When ordering Yale B-D Lok-Needles
Specify HUBER POINT

B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

Crystalline
PROCAINE PENICILLIN G
IN PEANUT OIL
Free Flowing

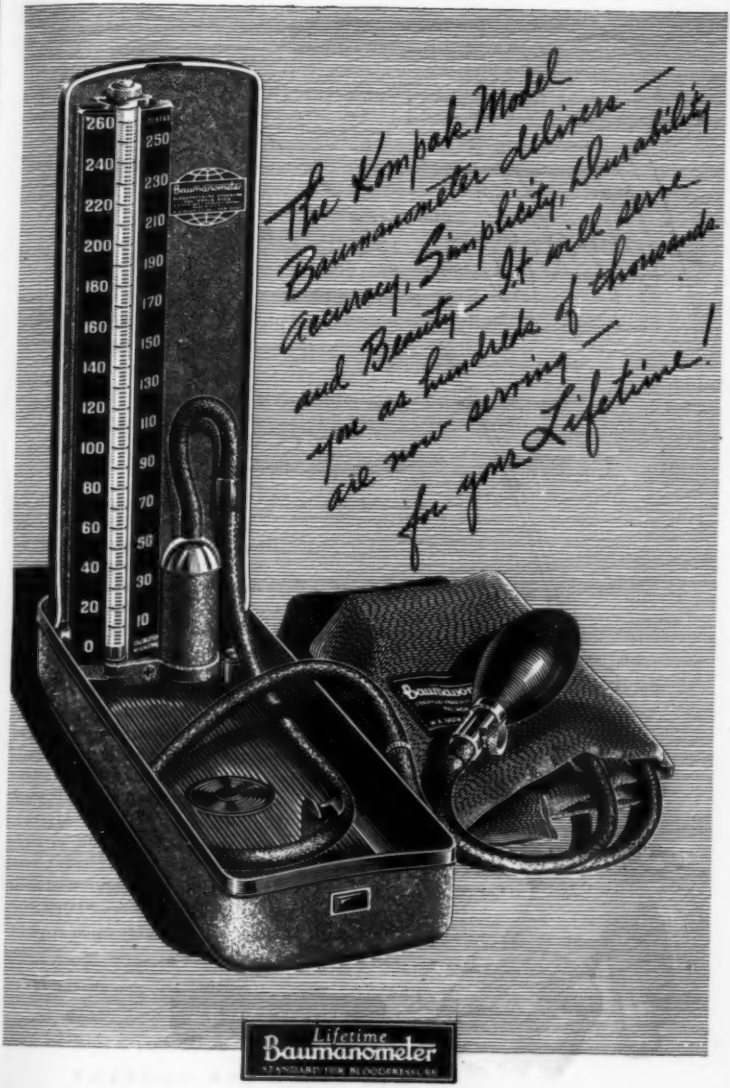
C·S·C



Crystalline Procaine Penicillin G in Peanut Oil-C.S.C. provides 300,000 units of penicillin per cc. It is virtually pain-free on injection, free flowing, heat stable, and contains no wax. A single 1 cc. injection (300,000 units) produces clinically effective blood levels for 24 hours in more than 94 per cent of the patients. Blood levels are plateau-like, sustained, and fully adequate. Indicated in the treatment of most penicillin sensitive infections. Average dose, 1 cc. (300,000 units) daily; in overwhelming infection, 2 cc. daily. Supplied in economical 10 cc. rubber-stoppered vials, each cc. containing 300,000 units of crystalline procaine penicillin G with 2% aluminum monostearate added.

C.S.C. Pharmaceuticals

A DIVISION OF COMMERCIAL SOLVENTS CORPORATION • 17 E. 42nd ST., NEW YORK 17, N. Y.



W. A. BAUM CO., INC. • NEW YORK 1

Panorama

Advertisement in a Buenos Aires newspaper: "Wanted—a doctor who can perform the operation described in the September issue of The Reader's Digest" . . . A 136-page "book of directions" comes with New York babies; it's attached to each birth certificate issued by the city . . . Two-way walkie-talkies, camera size, soon to be marketed at about $35 each; doctors in each community getting a special wave band for their exclusive use.

More physicians? Maybe—but the basic need is fewer patients, says AMA President Edward L. Bortz, in asking doctors to take greater interest in preventive measures: "Curative medicine is only one factor, and perhaps not a major one, in the development of a health program" . . . What next: Neurotics now have their own magazine, Neurotica, published by two St. Louis laymen . . . Why don't the armed forces swap a year of free medical education for a year of military service? suggests Rep. Donald O'Toole (D., N.Y.) . . . Physicians showing a quickening interest in salaried practice, reports Dr. Lucius W. Johnson of the American College of Surgeons.

New look: When a certain dye proved toxic to laboratory animals, anonymous doctor doing cancer research at University of Pennsylvania tried some on himself. He not only survived, reports the Associated Press, but "turned a handsome shade of blue" . . . Since drug addicts are sick men, not necessarily criminals, doctors should be permitted to prescribe opiates for them, says Dr. Alfred R. Lindesmith of Indiana University. This procedure has kept down addiction in England, he says. . . . Cost of medicinal whiskey is income-tax-deductible,

Announcing

COUNCIL ACCEPTANCE

of FURACIN in a new vehicle:

FURACIN SOLUTION

Furacin, the new antibacterial agent, is now also available in a liquid vehicle for use where a liquid is preferable to the ointment form, as for wet dressings.

Furacin Solution contains Furacin 0.2% (brand of nitrofurazone N.N.R.) dissolved in a bland, water-soluble, penetrating liquid vehicle composed of a wetting agent 0.3%, Carbowax 65% and water 34.5%. It is available at pharmacies in 4 oz. and 1 pint bottles.

Furacin Solution and Furacin Soluble Dressing are indicated for topical application *in the prophylaxis and treatment of infections of* wounds, second and third degree burns, cutaneous ulcers, pyodermas and skin-graft sites.

EATON LABORATORIES Inc.

NORWICH, NEW YORK • TORONTO, CANADA

LITERATURE ON REQUEST

rules California internal revenue agent—but only in the amount prescribed by an M.D. The tax agent adds solemnly: "It's difficult to say where dosing leaves off and drinking begins."

John's Other Life: John O'Donnell died in San Francisco Hospital; relatives shelled out $432 for burial, made claim on insurance company—but company found John alive. Red-faced hospital officials revealed they had had two John O'Donnells; when one died, they had notified wrong next-of-kin . . . Research on "reading pencil" being pushed by V.A.; it's an electronic stylus that translates printed words into code sounds in an earphone. When perfected, it may replace Braille for the nation's 250,000 blind persons . . . First Negro ever to get a tournament invitation from U.S. Lawn Tennis Association is a New York physician, Reginald S. Weir . . . "Don't put the cart before the horse—and then overload it," Congress has been warned by Dr. John P. Hubbard, American Academy of Pediatrics. Many areas have a crying need for school health services, he says, but Federally financed programs won't work unless funds are used first to train pediatricians.

Huge medical center, to cost $100 million, taking shape at Houston, Tex.; it will be part of Baylor University College of Medicine . . . Sharp landlords in some areas, keeping an eye out for increased rentals, use old zoning regulation prohibiting M.D. offices in exclusive residential sections as excuse for evicting doctor-tenants. Landlords conveniently overlooked rule when leases were signed.

Verbose and complicated, says Gov. J. Strom Thurmond, South Carolina, of both the Taft and Wagner health bills. Some Congressman, he adds, should write a simplified version incorporating best features of each . . . Doctors reportedly told Mrs. Frank Leo of Nutley, N.J., that only an operation could get the bobby pin out of little Teddy's bronchial tube. Whereupon Teddy coughed hard, spat out the pin . . . More understandable testimony by doctors is aim of coaching committee set up by Wisconsin medical and bar associations.

For **INTENSIVE** *Vitamin Therapy*

In manifest vitamin deficiencies it is inadvisable and impractical to rely primarily on dietary correction. The deprivation of essential nutrient factors usually has existed for many years, and it is important to give adequate treatment in order to restore health promptly.

Pluraxin is especially designed for intensive vitamin therapy.

SPECIAL THERAPEUTIC FORMULA

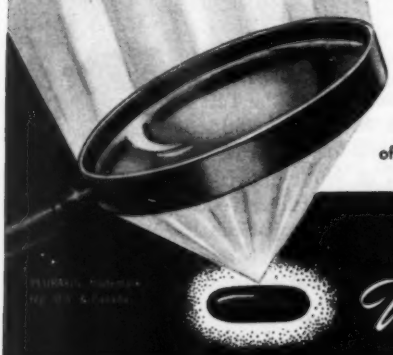
Vitamin A (from fish liver oil)	25,000 U.S.P. Units
Vitamin B_1 (thiamine)	15 mg.
Vitamin B_2 (riboflavin)	10 mg.
Vitamin B_6 (pyridoxine)	2 mg.
Nicotinamide	150 mg.
Folic acid	5 mg.
Calcium pantothenate	10 mg.
Vitamin C (ascorbic acid)	150 mg.
Vitamin D_2 (calciferol)	1000 U.S.P. Units

Pluraxin

WITH FOLIC ACID

High Potency Therapeutic Formula
Multiple Vitamin Capsules

One capsule of Pluraxin daily is usually sufficient. Some patients may require larger doses during the early stages of treatment. In vitamin therapy, "it is far better to prescribe too much than too little, too soon rather than too late" (Spies). Available in bottles of 30 and 100 capsules; same formula also supplied without folic acid, in bottles of 30 and 100 capsules.



WINTHROP-STEARNS

Winthrop-Stearns INC

NEW YORK 13, N. Y. WINDSOR, ONT.

diphtheria tetanus pertussis

combined

3 IMMUNITIES CONCURRENTLY CONFERRED

Combining three antigens into one preparation, Parke-Davis DIPHTHERIA-TETANUS-PERTUSSIS (Combined) stimulates simultaneously the production of antibodies protective against diphtheria, tetanus and whooping cough. Use of this effective and conveniently administered triple antigen greatly simplifies the immunization schedule—a factor of importance to physician, patient, and parents.

DIPHTHERIA-TETANUS-PERTUSSIS (Combined) is supplied in 3 cc. vials (one immunization course) and 15 cc. vials (five immunization courses). Each cubic centimeter contains 30,000 million phase I *Hemophilus pertussis* organisms and one immunizing dose each of diphtheria and tetanus toxoids. An immunizing course consists of three 1-cc. doses given subcutaneously at three or four week intervals.

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

MEDICAMENTA VERA

In Angina Pectoris

In Angina Pectoris the incapacitating symptoms frequently may be prevented by appropriately regulated administration of a vasodilator having a sustained effect. This type of medication may be indicated:

FOR THE PERSON

- *who suffers "indigestion" and "gas" after a heavy meal.*
- *who is compelled to stop and rest when climbing a flight of stairs.*
- *who is stricken with precordial pain on unusual exertion or emotion, or when exposed to cold.*

The vasodilatation produced by Erythrol Tetranitrate Merck (Erythrityl Tetranitrate Tablets U.S.P.) begins about 15 minutes after administration, and lasts from 3 to 4 hours.

Experience has shown that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of organic nitrates or nitrites. For prophylactic purposes—to control anticipated paroxysms—the delayed but prolonged action of Erythrol Tetranitrate is reported as especially useful. Erythrol Tetranitrate, because of its slow and prolonged action, also is of value for preventing nocturnal attacks.

ERYTHROL TETRANITRATE MERCK

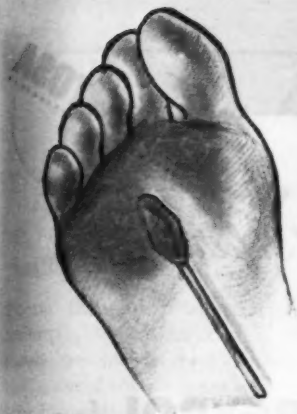
(ERYTHRITYL TETRANITRATE U.S.P.)

Council Accepted

MERCK & CO., Inc. RAHWAY, NEW JERSEY

Manufacturing Chemists

MERCK MERCK



get AT the fungus
in athlete's foot
with

decupryl

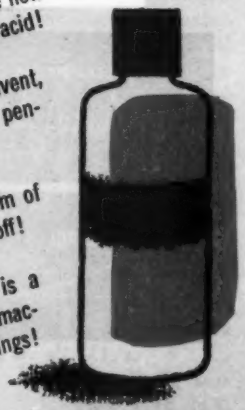
a NEW drug in a NEW fat-solvent volatile liquid base

NEW in effectiveness . . . contains the new and more fungicidal COPPER salt of undecylenic acid!

NEW in vehicle . . . a lipophilic, fat-solvent, low surface tension liquid that provides greater penetration of the fungicide!

NEW in prolonged action . . . the film of fungicide stays on and in the skin—will not rub off!

NEW in convenience . . . Decupryl is a rapidly drying liquid that avoids messiness and maceration of ointments; requires no protective dressings!



DECUPRYL—solution of copper undecylenate and undecylenic acid with a "wetting" agent in a volatile liquid base. Patent applied for. Available, on prescription only, in 1 oz. and 4 oz. bottles.

Crookes LABORATORIES
305 EAST 45TH ST., NEW YORK 17, N. Y.

To CROOKES LABORATORIES, INC.
305 East 45th St., New York 17, N. Y.

Please send me a sample of DECUPRYL, with detailed literature and special treatment routine forms for patients' use.

Dr._____

Street_____

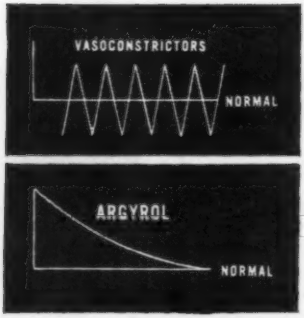
City_____ Zone___ State_____

In treating Para-nasal Infection

MEDICAMENTOSA

Avoid RHINITIS

℞ ARGYROL for decongestion without rebound



Rhinitis Medicamentosa—a result of repeated rebound congestion-is attributed solely to the use of vasoconstrictors.

Use of ARGYROL accomplishes the main purpose of treatment—the restoration of normal nasal function—without danger of inducing this chronic condition.

The ARGYROL Technique

1. The nasal meatus . . . by 20 per cent ARGYROL instillations through the nasolacrimal duct.
2. The nasal passages . . . with 10 per cent ARGYROL solution in drops.
3. The nasal cavities . . . with 10 per cent ARGYROL by nasal tamponage.

Its Three-Fold Effect

1. Decongests without irritation to the membrane and without ciliary injury.
2. Definitely bacteriostatic, yet non-toxic to tissue.
3. Cleanses and stimulates secretion, thereby enhancing Nature's own first line of defense.

ARGYROL *the*

Medication of Choice in treating Para-nasal Infection

Made only by the

A. C. BARNES COMPANY • NEW BRUNSWICK, N. J.

ARGYROL is a registered trade mark, the property of A. C. Barnes Company

Speaking Frankly

Sniffles

Poetic thoughts after reading in MEDICAL ECONOMICS that a California psychiatrist had discovered the cause of the common cold (disappointment over not receiving Christmas presents):

Have you snuffled?
Have you sniffed?
Didn't you get your Christmas gift?
Not on Santa Claus's list?
Quick! To a psychiatrist.
His prescription will be pleasant:
"Rx—Take one Christmas present."
Psychiatry is sure and simple:
Find the id, cure the pimple.
Still I'm yearning to know why
I catch cold in mid-July.

Edgar L. Dimmick, M.D.
Brooklyn, N.Y.

Consultation

Recently I was asked to see a patient in consultation with Dr. G. After billing the patient several times without results, I finally received this reply from him:

"When I was in the hospital, I was under Dr. G.'s care. I have since paid his bill in full. Since I did not call you, I don't feel that I am indebted to you. If Dr. G. wanted your advice, let *him* pay for it."

G. W. Monteleone, M.D.
Port Jervis, N.Y.

Preventive

Your editorial, "Self-Prescription," hit me right between the eyes. Some months ago I set up just such a program of general disease-detection. I now devote two mornings a week to the work and give thorough examinations consisting of a complete history and physical, chest X-ray, blood count, urinalysis, and Wassermann. For patients over 40, I add an electrocardiogram and a determination of the sphygmo-oscillometric index. The fee is small and patients' reactions are excellent.

I believe the profession's future lies in just such preventive work being done by all G.P.'s.

Leon Paris, M.D.
New York, N.Y.

Audit

I can't agree with criticisms of the staff audit that are voiced in your April article, "Box Score for Staff Physicians." If the audit is conducted without prejudice, there can

Use the *safest* antihistaminic *first*

"Clinically, Neohetramine has an advantage over all other antihistaminics investigated, in that it is *extremely well tolerated*, and may often be used successfully in patients who are unable to take other drugs of this series because of unpleasant side actions."

Friedlaender, S., and A. S. Friedlaender, American College of Physicians, Milwaukee, 15 Nov. 1947.

Wyeth

DISTRIBUTED BY

WYETH INCORPORATED

. . . Neohetramine

Neohetramine is by far the safest antihistaminic. Only 1 per cent of 1000 patients had to discontinue treatment because of side effects characteristic of antihistaminic drugs.

Controlled clinical studies emphasize the effectiveness of Neohetramine in most cases of hay fever, vasomotor rhinitis, urticaria, allergic dermatitis, drug sensitivity and other allergies. There are also favorable reports on asthma and migraine. In fact many patients have been helped by Neohetramine after other antihistaminics had failed.

Since Neohetramine is effective as well as safe, it is the logical antihistaminic to *try first.*

Dosage: 50 to 100 mg. three or four times a day, preferably after meals and at bedtime.

25, 50, and 100 mg. tablets, bottles of 100 and 1000.

TABLETS

Neohetramine

Trademark

BRAND OF THONZYLAMINE HYDROCHLORIDE

N,N-dimethyl-N'-paramethoxybenzyl-N'-(2-pyrimidyl) ethylenediamine monohydrochloride, made by Nepera Chemical Company, Inc.

PHILADELPHIA 3, PA.

be no attempt to "smear" any physician. If the audit isn't done honestly, something is wrong with the hospital that no audit can correct.

An audit conducted openly is the best means of improving hospital standards. Our staff has accepted it enthusiastically for more than eight years. It would object strenuously to giving it up.

Frederick T. Hill, M.D.
Waterville, Me.

Critics of the staff audit seem to overlook these points:

1. Since physicians are human, grounds for criticizing them can always be found. But the audit is not only critical; it aims also at proving competence.

2. Any physician may make a mistake in estimating an emergency. But repeated "mistakes" to secure precedence in the operating room are prevented through use of the audit.

3. The system has not had whirlwind acceptance, it is true. But as far as I know, the audit has not been thrown out of any hospital in which it has been installed.

Thomas R. Ponton, M.D.
Yucaipa, Calif.

Storehouse

In referring to the services of the Army Medical Library, a recent article in MEDICAL ECONOMICS stated: "For the price of postage you can get books, slides, pamphlets, journals, photographs, and microfilms."

The Army Medical Library is in-

This is the type of advertising Beech-Nut is running in newspapers and magazines to reach mothers

Babies know, too, that Beech-Nut meal time is happy time.

Two people whose judgment you can depend on!

Your baby knows *when* he wants to eat, and how much.

Your baby's doctor knows *what* the baby should eat and every mother should seek the advice of a food specialist in infant feeding.

There is but one more important matter for mothers to remember: Beech-Nut has always cooperated with doctors in the selection and processing of baby foods. They are scientifically prepared—the natural food values and flavor are retained in high degree. You never go wrong with Beech-Nut.

Beech-Nut FOODS for BABIES

"ACCEPTED"

Beech-Nut high standards of baby food production and all Beech-Nut baby food advertising have been accepted by the Council on Foods and Nutrition of the American Medical Association.

A complete line of Beech-Nut Strained and Junior Foods—Meat and Vegetable Soups, Vegetables, Fruits and Desserts.

ALWAYS PACKED IN GLASS

deed complimented by this announcement. However, the service we are able to give is slightly exaggerated. There are available through interlibrary loans (or at the library itself) books, journals, theses, duplications, and a collection of portraits of medical interest. Microfilms and photostatic reproductions of articles are available to the public at cost.

Slides, popular pamphlets, and reprints are not available through the Army Medical Library.

J. H. McNinch, Col., M.C.
Army Medical Library
Washington, D.C.

Raise

Congress recently boosted the base pay of Regular Army and Navy doctors by $100 a month. But ASTP students who must serve two years in the Army after graduation won't get that raise. To me, it sounds like discrimination.

Robert J. Hansell, M.D.
Greenwich, Conn.

Offices

Shall modern hospital facilities include doctors' offices? I say "Yes!"

A group of doctors today can scarcely afford the cost of an elaborate office, complete with expensive laboratory, X-ray, and other equipment. Why not use the clinical facilities of hospitals, cut down on uneconomic duplications, and incidentally avoid the tax burden that falls on buildings and equipment used exclusively by private M.D.'s?

M.D., Kansas

from adolescence to old age...

woman's need for iron

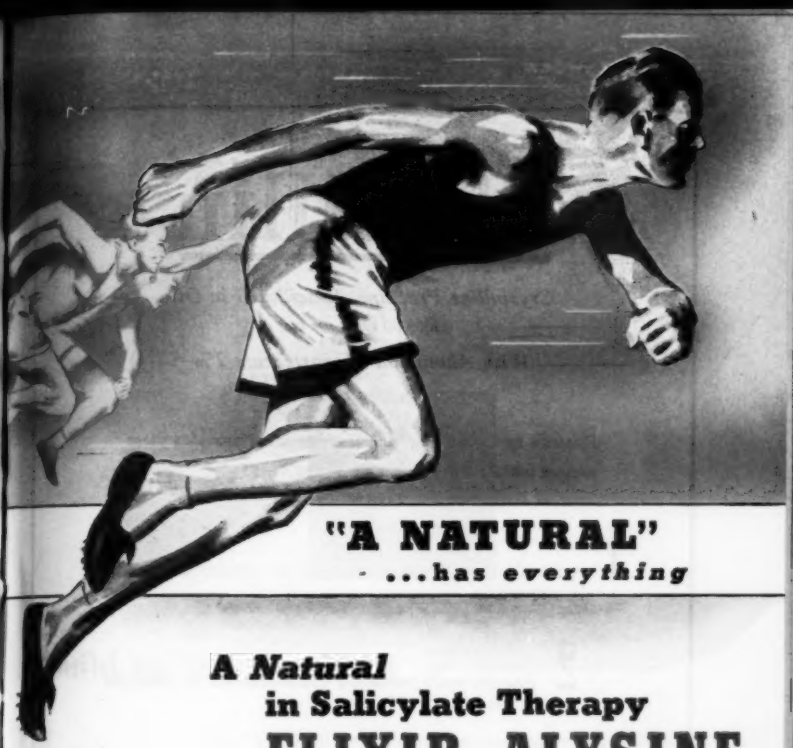
never ceases

In adolescence... After menstruation has set in... Throughout pregnancy and lactation... During the menorrhagia which so frequently precedes the menopause... And even in old age, women's hemoglobin levels should be closely watched and iron therapy instituted when indicated.

Adequate dosage of ferrous sulfate—grain for grain the most effective form of iron—is supplied by FEOSOL TABLETS.

Smith, Kline & French Laboratories, Philadelphia

The standard form of iron therapy



"A NATURAL"

...has *everything*

A *Natural* in Salicylate Therapy

ELIXIR ALYSINE

A Distinctive Combination of Merrell's Natural Salicylate and Alkaline Salts

Elixir Alysine, containing approximately 0.3 Gm. (5 grs.) natural sodium salicylate and 0.6 Gm. (10 grs.) alkaline salts per teaspoonful, in 4-oz., pint and gallon bottles.

Also available as

Alysine Powder, containing approximately 0.6 Gm. (10 grs.) natural salicylates and 1.2 Gm. (20 grs.) alkaline salts per level teaspoonful, in 1-oz., 4-oz., and 1-lb. bottles.

In the symptomatic treatment of the common cold, influenza, la grippe, tonsillitis, rheumatic fever and arthritis, Elixir Alysine is the *natural* choice.

Containing *natural* salicylates prepared solely from oil of sweet birch, together with selected alkaline salts, Alysine provides fast, intensive salicylization with a minimum of gastric irritation or systemic acidotic tendency.

In a palatable, aromatized solution, Elixir Alysine is immediately assimilable for quick therapeutic response and readily adaptable to fractional dosages.

Used adjunctively with the sulfas, Alysine provides an alkaline (tolerance) factor, and at the same time helps to relieve muscular aches and pains.

Trademark "Alysine" Reg. U. S. Pat. Off.

MERRELL

THE WM. S. MERRELL COMPANY • CINCINNATI, U.S.A.

Flo-Cillin

Crystalline Procaine Penicillin G in Oil

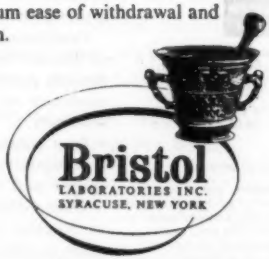
(300,000 units per cc.)

With Aluminum Monostearate 2%

Bristol's new penicillin repository product provides these unique features:

1. A free-flowing, liquid product which remains constantly in suspension.
2. Exceptionally sustained concentrations of penicillin in the blood.
3. Complete uniformity of dosage.
4. Maximum ease of withdrawal and injection.

Available through your usual source of supply in vials containing ten 1 cc. doses of 300,000 units per cc.



to build up the run-down

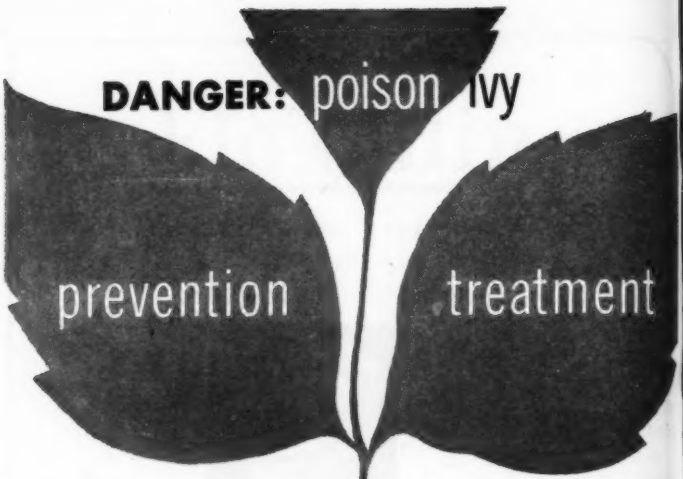
The "generally run-down" patient more often than not is the product of mild nutritional deficiencies caused by loss of appetite.

Eskay's Theranates is the ideal tonic to restore appetite . . . and to increase vigor and general tone. It is light and easily tolerated; its pleasantly tart taste never becomes monotonous.

Smith, Kline & French Laboratories, Philadelphia

Eskay's **Theranates**

The formula of famous Eskay's Neuro Phosphates plus appetite-stimulating Vitamin B_1.



TO ELIMINATE CONTACT:

Patients must learn to identify and avoid poison ivy

To help your patients, an exact cut-out reproduction of a poison ivy leaf has been prepared. This Calmitol "Ivy Leaf" also presents a few simple criteria for plant identification.

Patients must learn to take proper action upon exposure

To help patients who have been exposed, the Calmitol "Leaf" lists a simple prophylactic procedure. If a rash appears, patients are instructed to see their physician.

The Calmitol "Ivy Leaf" is a medical service of Thos. Leeming & Co., Inc. Suitable quantities for practicing physicians, school doctors, and camp physicians may be obtained by writing: Thos. Leeming & Co., Inc., 155 East 44th Street, New York 17, N.Y.

FIRST THOUGHT IN TREATMENT:

Control of itch in dermatitis venenata is singularly simple with Calmitol. Its active antipruritic ingredients, camphorated chloral and hyoscyamine oleate promptly block transmission of the pruritic sensation at the point of origin by raising the local threshold of the receptor organs and sensory nerve filaments. Calmitol's special clinging base helps achieve hours of relief and protection against contact and friction.

Extreme blandness and freedom from potentially dangerous phenol, cocaine and their derivatives recommend Calmitol not only for the pruritus of simple summertime dermatoses but also when itch must be controlled in pediatric, gynecologic, allergic and industrial practice.

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Sidelights

Behind the Embroidery

The habit of looking at a man's labels rather than at his skills has in recent years gained many addicts. Diplomas and certificates are too often the standards used, to the exclusion of performance in the sick room.

Insurance companies are loath to place a doctor on the witness stand unless he can dazzle the jury with a long string of degrees and affiliations. The V.A. wants only board diplomates for service chiefs. The best medical teacher in the country would probably be kept off the average school's faculty unless he sported some extra label. Plain M.D. isn't enough.

During the war, some 50,000 doctors learned by experience (some of it bitter) how much weight can be given to stars, bars, and leaves. And today, hospital trustees shudder when an uncertified specialist aspires to higher ward or clinic rank. Meanwhile, journalists, hipped on "improving medical care," warn lay readers to trust themselves only to hospital service chiefs, board diplomates, or fellows of scientific societies.

Maybe it's all a sign of progress. But we can't help hankering for the days when merchandise was accepted more on the basis of the stuff inside the package than because of the lettering on the label.

Reporter's Report

"Replete with errors and misstatements," said a recent AMA "Secretary's Letter," referring to our March article on the delegates' interim meeting. What apparently had riled some AMA trustees in Chicago was the report that they had harbored misgivings about the new Council on National Emergency Medical Service and that they had short-changed the council on its appropriation.

The buckshot charge loosed against the article overlooked one important point: The opinions it contained were given not as those of our reporter but as those of delegates and council members with whom he had talked. He had uncovered a feeling that the trustees were not cooperating fully with the new council, and he had done his job by reporting it.

If, as the "Secretary's Letter" says, the Council on National Emergency Medical Service now "has the confidence and support of

the Board of Trustees," we're glad to know it. Perhaps the article in question helped bring this about. Meanwhile, our reporter is cheerfully adding a new tidbit to his "oddities" file: The article "replete with errors and misstatements" had been checked for accuracy at AMA headquarters before publication.

Wayward Youth

Reports filter in occasionally to the effect that young physicians are pretty apathetic about the threat of state medicine. Some junior members of the profession—particularly those competing for practice in large cities—are said to take the stand, "What have we got to lose?"

One reason for this attitude is that men in (or just out of) medical school don't have enough chance to absorb the views of private practitioners. As AMA Trustee James R. Miller puts it, "Medical students are likely to hear much of the alleged advantages of socialization from physicians who themselves have not indulged in personal medical practice."

Older physicians who rub elbows with young M.D.'s could well spend some time pointing out why their juniors have more to lose than they think. They could explain why the Wagnerian prospect, which may look attractive from the bottom rung, is less so from any other vantage point. At the same time, medical societies could profitably look into the advantages of offering student memberships.

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since they had CUTTER FORMULA B.I.P.*

Lots of nice old ladies and gentlemen, who once called wheel chairs "home," are finding arthritic pain relieved — their joints more limber—after treatment with B.I.P.*

Cutter Formula B.I.P. (Bacterial Intravenous Protein) is the new name for Cutter Arthritis Vaccine-Sherwood Formula — more accurate because the more that's known about it, the more evidence there is that it creates a protein desensitization rather than any antigenic response.

Not that we can state just *how* B.I.P. alleviates pain—or why it appears to slow progress of the disease. Reports from the profession, however, assure us that it *does* —in a large number of cases.

B.I.P. contains 1,000,000 organisms per cc., including polyvalent strains of Streptococci and Staphylococci (each 30%), and M. catarrhalis, B. friedlanderiae, and B. influenzae (each 10%).

Will B.I.P. cure or help all patients? No. It's a safe way to start, however, and it carries none of the hazards of gold. Results follow B.I.P. therapy in too high a percentage of cases to be shrugged off as "natural ebb and flow of symptoms."

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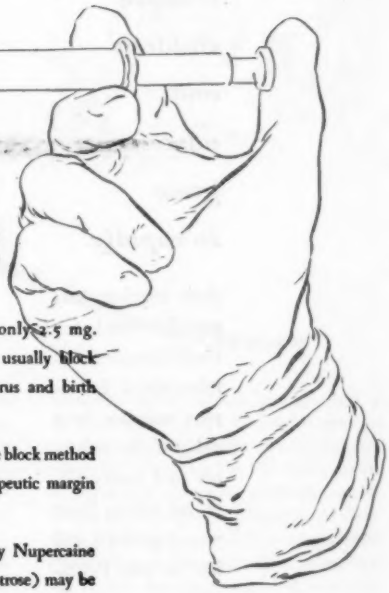

An intraspinal injection of only 2.5 mg. (1/25 gr.) of Nupercaine will usually block sensory impulses from the uterus and birth canal for 1½ to 3 hours.

The inherent safety of the saddle block method is enhanced by the wide therapeutic margin of intraspinal Nupercaine.

Now in a single ampul, Heavy Nupercaine (Nupercaine 1:400 and 5% dextrose) may be injected without mixing and without dilution.

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Heavy Nupercaine — ampuls of 2 cc. in cartons of 10. Sales limited to hospitals.

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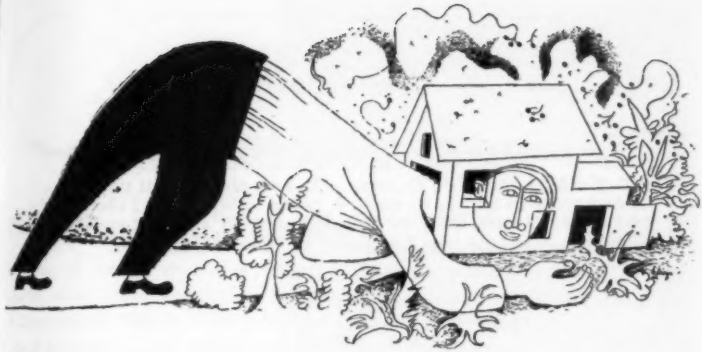

he won't have to stay in hiding this season

... and many more hay fever patients will be able to end their ostrich-like existence. They can tolerate moderate exposure to pollen, yet remain symptom-free or definitely improved—with Abbott's *new*, effective antihistaminic drug, THENYLENE Hydrochloride.

Written clinical reports have proved THENYLENE about 70 percent effective in hay fever cases. The incidence of side-effects is low. After receiving a number of different antihistaminics, a significant percentage of patients in one test group preferred THENYLENE Hydrochloride because of fewer side-effects.

As with all symptomatic remedies, complete relief cannot be expected in all cases; the drug should be used as an adjunct to specific desensitization wherever possible. On the other hand, THENYLENE may help patients not relieved by previous antihistaminic therapy. While no harmful effects have been reported, a total daily dose exceeding 0.4 Gm. is not recommended, nor continuous use beyond eight weeks.

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com·plete' (kŏm·plēt'; 2), *adj.* [L. *completus*, past part. of *complere* to fill up, fr. *com-* + *plere* to fill] 1. Filled up; with no part lacking. Brought to an end; ...

Protein synthesis has long been held to be a case of "all or none." To form a body tissue, every component must be available. Amino acids traced with isotopes evidence, too, that when the anabolic action starts it is rapid.

Breogamine, the new preparation for protein alimentation, is a source of all amino acids essential to man. It is nearly all protein; not thinned with less expensive vitamins and flavoring that sometimes obscure small protein content. Breogamine is "complete—filled up, with no part missing."

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Editorial

New Hope Dept.

• Few of us in medicine would think of likening Federal Security Administrator Oscar Ewing to the Good Samaritan. Yet, oddly enough, this man who would socialize us has also done us a good turn. He has opened the way to a new and better understanding between the providers and the consumers of medical care.

Offhand, that may sound like so much high-flown malarkey. Its real value shows up only when we look closer:

Last month, at Mr. Ewing's bid, some 800 people went to Washington to take part in the National Health Assembly. Among them were a lot of skeptics—this writer for one. Mindful of the shamelessly rigged National Health Conference held in 1938, these Doubting Thomases could perhaps be excused their point of view.

As the assembly gained headway, the wonder of wonders became evident: Each side was actually listening to the other—and attentively. Each began to admit some logic in the other's case.

The left and the right weren't sleeping together – and probably never would. But they *were* showing a desire to try to get along. And for them that was something. No group – not even the minority of M.D.'s present—felt that it was being pushed around or slighted.

Such name-calling and nose-thumbing as took place was negligible. It centered around personalities, not principles. Nelson Cruikshank of the AFL, for example, rapped Morris Fishbein of the AMA for a violation of conference ethics (see article on the assembly, in this issue). Doctor Fishbein had previously pooh-poohed both the AFL and the CIO as "minor groups" clamoring for compulsory health insurance. The to-do that resulted was a diversion, not a disruption. The conferees made it clear that they were on hand to stake out areas of agreement, not to indulge in arguments that would get them nowhere.

Proof of this earnestness was the delegates' request at the closing session for a repeat performance. Many urged that a National Health Assembly be held yearly—or at least more often than once a decade. They also asked for early, follow-up meetings on a smaller scale, be-

[*Continued on* 36]

tween organized medicine and the consumer groups.

No decision was reached on the next national assembly, but arrangements were made for the smaller meetings to begin sometime after the first of this month (June), with the AMA as host. The idea here is for doctors to sit down, in turn, with representatives of farm, labor, co-op, and similar organizations to continue ironing out differences and to decide what next steps shall be taken.

While obstructionist tactics are wholly possible at these forthcoming AMA-consumer talks, it seems likely that the cooperative spirit picked up by leaders of both sides while at the National Health Assembly will make them intolerant of any small-time saboteurs.

Winning friends and influencing people among the consumer groups offers prime advantages: Medicine can improve its public relations to an extent not otherwise possible. The man in the street will conclude that doctors, after all, are people and that they want to further, not retard, new plans of medical service that are good for the public. Impetus can be given as never before to medical prepayment, hospital construction, public health, and other activities that demand joint lay and medical effort. Result: better medical care for the patient and greater satisfaction for the doctor in doing his life's job.

There's as much truth in the charge that most labor leaders are radicals as there is in the charge that most doctors are reactionaries. To our Hatfields and our McCoys, it may therefore be said, "We've had our fightin', our feudin', and our fussin'. Now let's start patching things up. There's plenty to be done for the good of us both."

Quincy Howe of CBS summed up the work of the National Health Assembly at its final session. One of his remarks deserves repetition. Said he:

"It is the great achievement of this assembly that so many experts in so many fields have reached agreement on so many subjects ... That so many doctors have shown themselves so cooperative, so understanding, so open-minded seems to me the most promising and the most important development of this whole meeting. The example the doctors have set here should encourage all of us to go on with the kind of work that this National Health Assembly has only just begun." —WILLIAM ALAN RICHARDSON

Your Assignment in World War III

Doctors help draft blueprint for agency to assign M.D.'s to military, civilian posts

• As of last month, we had no national plan for civilian medical care in case of war. The agency that would draw up such a plan had not even been created. Nevertheless, there was evidence of some progress since last February, when MEDICAL ECONOMICS had reported an almost complete lack of preparation for the huge civilian casualty load the next world war would bring.

Not far from Capitol Hill, in Washington, a small group of men was working to draft legislation that would create a new civilian defense agency. The proposed law was expected to be ready for Congressional action within a few weeks. Should it be adopted, physicians could, for the first time, be sure an overall plan was in the making. They might also begin to get an inkling of their particular role in the civilian wartime medical program.

Boss of the law-writing project was a Nebraska businessman, Russell J. Hopley, president of the Northwestern Bell Telephone Company. To assist him, he had assembled spokesmen for key defense industries as well as legal and medical advisers.

Heading the medical section of this group was Dr. Perrin Long, well-known internist and professor of preventive medicine at Johns Hopkins. To help write the medical parts of the proposed law, Doctor Long was calling on consultants from the AMA, from the drug industry, and from the nursing, social service, and allied professions.

Who'll Be Boss?

The Hopley group was finding it necessary to weigh a number of delicate questions. Among the touchiest were these: Should the proposed civilian defense chief be subordinate to the Secretary of Defense? Should he be on an equal footing? Or should there be a brand-new department to boss both military and civilian forces?

The odds were on a new super-Department of Defense. But the responsibility for assigning physicians to the armed forces and to civilian medical care posts would probably remain in an independent agency. Last month leaders of organized medicine were hoping a new medical council would be set up within

the National Security Resources Board to do the job.

Outside the Army and Navy, most wartime medical planning up to last month had been in the hands of two committees headed by Maj. Gen. Paul R. Hawley. One committee was reporting to Arthur M. Hill, chairman of the National Security Resources Board. It was concerned with mobilization to support the military medical forces, but it had never really been very active.

The other committee (part of the Department of Defense) was charged with getting closer tie-ins among Army, Navy, and Air Force medical departments. Neither Hawley committee had the facilities or the authority to frame a civilian medical care plan of the scope doctors thought necessary.

In the event Congress created a new agency, it seemed certain last month that a number of physicians would be given important parts to play. Here's why:

(1) Interest in U.S. preparation for emergency civilian medical care had first been stirred up by a small group of physicians. These men had beaten everyone, including the Government, to an early recognition of the problem and to study of it.

(2) A number of medical men had helped with post-war surveys of German and Japanese civilian medical organization. They had learned what a heavily bombed country needs.

Some of these doctors were members of the AMA Council on Emergency Medical Service. They seemed destined to contribute heavily as individuals to U.S. war planning, even though the AMA council as such might have only minor advisory functions. State and county medical society committees also were likely to take substantial parts in setting up a civilian medical care system, especially in collecting data on personnel and facilities.

Last month, however, neither the societies nor individual M.D.'s could do a great deal. Next step toward medical preparedness was for the Hopley board to finish blueprinting an agency that could correlate military and civilian medical needs. Then, if Congress took action on their proposal, the real planning could be started.

—EDMUND R. BECKWITH JR.

Announcements Without Frills

Here are some down-to-earth cues on announcing a new event in your professional life

• "Men! You'll go for Doctor Smith's straight-from-the-shoulder diagnoses. Ladies! Doctor Smith's hands are never cold. Don't wait—visit the Smith Clinic today. Doors open 2 P.M."

In such whoop-and-holler tones might a professional tub-thumper let the public know that Doctor Smith had opened a new office. Perhaps it's such thoughts of what doctors' announcements could be that keep them what they are: dignified statements, in modest typography and style, that tell patients certain essential facts about your practice.

A short, ungarnished sentence is all it takes. Here are some of the traditional phrases to rely on:

¶ Opening an office: John H. Smith, M.D., announces the opening of offices in the Medical Building, White Plains, Kansas.

¶ Change of address: . . . the removal of his office to 333 North Avenue on or about June 1.

¶ New office hours: . . . the following change of office hours, effective June 15 . . ,

¶ Change to specialty: . . . that after June 1 his practice will be limited to diseases of the skin.

¶ Completed post-graduate course: . . . that he has completed a year of study at the Blank Clinic and will resume practice on the seventh of June.

¶ Succeeding to another's practice: . . . that he will carry on the practice of Alfred G. Jones, M.D., and has possession of all his patients' case histories and records of treatment.

¶ Long vacation: . . . that he will return from vacation on July 30 and resume practice at that time.

¶ New associate: . . . that Dr. Bruce Elgin has become associated with him in the practice of surgery.

Physical Appearance

With slight alterations, one of these phrases will probably fit your situation. The only other things you need add are your address, your telephone number (home and office), and your office hours.

The announcement card itself is generally of white, dull-finish vellum. For a more formal note, thinner, kid-finish stock may be used. An announcement printed on the front of a folded sheet of this stock has

[*Continued on* 159]

WHAT THE CHIROPRACTORS ARE P T

Cultists, using new ideas to bolster thinning ranks, get around medical practice acts

● A physician eavesdropping on last month's annual chiropractic convention might have thought at first that things hadn't changed much. His ears would soon have been ringing with the cult's long-standing aims: (1) to convince the public that chiropractic has scientific value; (2) to turn public conviction into legislative pressure; (3) to establish chiropractic legally as a separate healing art; and (4) to recruit new members for the cult.

But while their goals are still the same, today's chiropractors are talking about some intriguing new ways of reaching them. For example:

A late addition to the cult's dri for public sympathy is a much-pu licized, 3,000-bed "research cent being built in Denver, Colo. Arc tects' sketches of the center are i pressive. So are the center's hig sounding purposes. And if you l ten to the Citizens' Chiropract Legions—lay organizations seeki to create political pressure for chiro practic—the Denver center is con vincing evidence that the cult i taking long scientific strides.

As public opinion warms to chir practic, increasing pressure will b applied against medical practi acts and against other legal restr tions that its practitioners now fi onerous. Simultaneously, anothe campaign will be stepped up: Chi ropractors want the right to partici pate in the Veterans Administration medical care program.

To describe the overall aims of U.S. chiropractors in 1948, the heads of ten chiropractic schools recently drew up a manifesto. For any member of the cult who can't understand its purposely ponderous phrasing, B. J. Palmer, son of chiropractic's inventor, gives a down-to-

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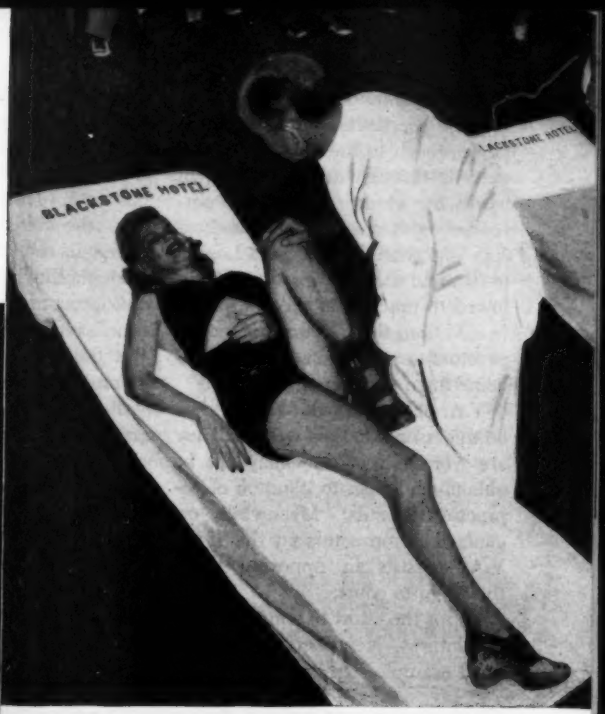
**Morris Weintrob, M.D., author of this article, is chairman of a special investigating committee of the Medical Society of the County of Kings (N.Y.). His indefatigable probing into chiropractic and his exposes of chiropractors have made him the* bete noir *of members of that cult.*



PLUM for publicity-conscious chiropractors comes at their annual convention when they test their handicraft on scantily-clad bathing beauties furnished by Florida press-agents.

APPLE pie for those who seek chiropractic schooling is New York's failure to enforce law against the cult.

earth translation. Says Palmer:

"We have been kicked around long enough. We are serving notice that we are banded together in a militant, united effort to establish chiropractic as a separate and distinct philosophy, science, and art.

"Our object is a decision of the U.S. Supreme Court. There is to be no compromise with present legislation classing chiropractic as anything but chiropractic. There are to be no side-issues. All effort is to be directed from now on toward

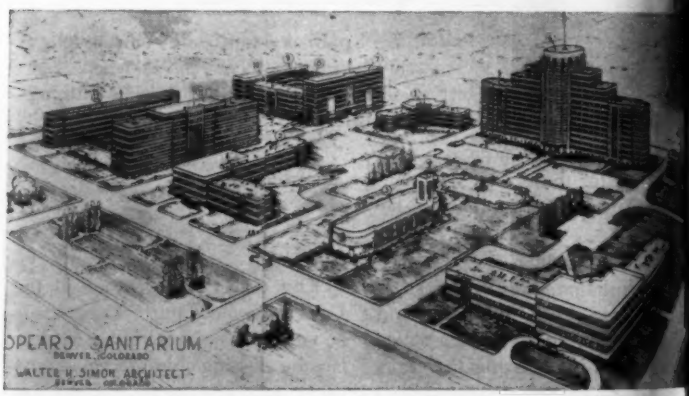
this one outstanding objective."

Some people think the chiropractic approach to the Supreme Court may lie through the V.A. Diligent work by chiropractors has persuaded both the Veterans of Foreign Wars and the American Legion to demand that chiropractors be allowed to practice in V.A. hospitals. In addition, the VFW wants chiropractors to participate in the V.A.'s home-town program.

V.A. officers say the Federal law on this issue is loosely written. They are worried that they may not be able much longer to stand off chiropractic demands. Meanwhile, organized chiropractors say that if the V.A. persists in opposing them, they'll go to court.

As for the effort to win over state legislatures, New York provides a good example. In that state, chiropractic is still illegal. A few yea ago a bill to establish a separa licensing board for chiropracto was beaten in committee by on one vote. Heartened by that nea miss, the cult got a new bill intro duced in the assembly. To help i through the legislature, New Yor chiropractors raised an "educationa fund" reported to total $500,000 But the bill failed to come out o committee.

Besides raising funds, the chiropractors are fast building their Citizens' Chiropractic Legions into ag gressive political cells. At one legion meeting attended by the au thor, some 200 people were shown before-and-after pictures of patient treated by chiropractors. Then, as the audience responded to this dem onstration of chiropractic's worth, the tone of the meeting switched



RESEARCH CENTER now being built gets big play in all chiropractic publicity. It will carry name of Spears family who are its trustees.

Denunciations of physicians' attempts to "strangle this new science" became loud and long. New converts were made to chiropractic's cause.

Though such local groups are in the vanguard of the legislative fight, overall direction comes from the national chiropractic bodies. Largest and most influential of these today is the National Chiropractic Association. Its functions are to protect members who run afoul of the law and to aid passage of helpful legislation. (But even the NCA has been able to corral but a small part of the cult. Mutual distrust among chiropractors is strong. Only about one-third belong to any association.)

Fastest growing of the new organizations is the American Society of Military Chiropractors. You might think from the title that its members practiced chiropractic in the Army and Navy. Actually, they are veterans who served non-professionally. The ASMC's estimated 3,000 members (soon to be joined by some of the veterans studying in

[*Continued on* 166]

HIGH PRIEST B. J. Palmer is son of chiropractic's inventor. B.J. has made a fortune by combining teaching of chiropractic mysteries with tie-in sales of adjusting equipment needed in practice.

STATEMENT OF ACCOUNT WITH

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MONTHLY STATEMENT of your market transactions: Assume, for example, that you believe XYZ common stock will advance from 60 to 70. You send your broker $4,600. You instruct him to buy 100 shares at the market price and sell them ten points up. The broker buys the 100 shares of XYZ common at the market price of 60. On receipt of the stock certificate, he pays $6,000, using your $4,600 plus $1,432 he borrows (you pay interest on the borrowed amount). Fifteen days later the market advances ten points and the broker sells your 100 shares at 70. At the end of the month, he sends you a statement like the one above.

Dealing With Your Stockbroker

Some tips to keep in mind when opening an account and following it through

• To open an account with a stockbroker, you start by making a deposit of funds or securities. You then sign a signature card giving your residence, occupation, citizenship, and references. If it's to be a joint account with your wife, she'll have to do some signing too. After that, you're ready to do business on a cash basis.

If you intend to buy and sell on margin, you'll also sign a "margin agreement." That gives the broker the right to reduce when necessary the amount you owe him by liquidating certain of your securities.

When you buy stocks outright, you pay the entire cost of the shares plus a commission for brokerage. The commission amounts to 6 per cent if the transaction is between $15 and $100. The rate drops as the size of the transaction goes up. Above $4,000, the fee is 0.1 per cent of the money value plus a flat $26. Thus, 100 shares of XYZ stock selling at 60 would cost you $6,000 plus $32 commission.

If you want to hold your own stocks, you can have them delivered directly to you after a cash purchase, then collect your own dividends. But many investors prefer to leave their securities with the broker and have him credit dividends to their account. For this service they may pay an extra fee.

Collecting Dividends

Buying on margin is a slightly different proposition. You pay only a part of the purchase price of the stock; the broker advances the rest. You pay interest on the advance until you resell the stock or pay off the loan. In the meantime, the broker holds the certificates as collateral. Should your account fall

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**Edmond duPont, author of this article, is a senior partner of Francis I. duPont & Co. In explaining stock market procedure, he has necessarily included an explanation of "short" and "margin" transactions.*

The editors recommend that dealings of this nature be carried on with extreme caution. ¶ No portion of Mr. duPont's article may be reproduced without the permission of the publisher.

market price and sell them ten points up. The broker buys the 100 shares of XYZ common at the market sells your 100 shares at 70. At the end of the month, he sends you a statement like the one above.

below the margin requirement during that period, your broker will call for covering funds. If they aren't forwarded immediately, he

has the right to sell enough stock to meet the requirement.

To sell stock held in your own name, you endorse the certificate and have the signature witnessed, leaving blank the rest of the spaces on the reverse side. You pay the same commission when you sell as when you bought, but this time you must also pay state and Federal transfer taxes.

A simple order to your broker is all it takes to sell stock you hold on margin. The proceeds of the sale, less commission and taxes, are credited to your account.

Not quite so simple is the business of selling "short." In this operation, you give your broker an order to sell stock you don't yet own. He executes the sale at prevailing market prices, then makes delivery with borrowed stock. At a later date, he buys stock to replace the stock he borrowed. In the intervening period, if the market has dropped, you profit. If prices have gone up, you lose the difference between your selling price and the buying price.

Your broker charges no interest on a short transaction, but you're required to place a specified margin. Then, too, there's a rental fee or premium if the stock is scarce. Another point to remember is that a short seller must pay to the lender any dividends declared on the stock the broker has borrowed.

Your broker must be specifically advised if you intend to make a short sale, since these transactions are covered by special rules. A short sale cannot, for example, be made at a price below the last regular selling price. And stocks can be sold short only if they are on the upgrade.

Limiting Losses

Many traders resort to "stop orders" to limit losses or to safeguard profits. These are orders to the broker to buy or sell stock when the price rises or falls to a specified mark. For example, a person may buy 100 shares of stock at 68 but want to unload them if the price falls to 64. He sends an order, "Sell 100 shares of XYZ stock at 64 Stop G.T.C." (G.T.C. means the order is good till canceled.) When the stock declines to 64, the stop order

automatically becomes a market order. It is carried out at the best available price.

Conversely, if an investor sends his broker a buy stop order—*e.g.*, "Buy 100 shares of ABC stock at 68 Stop G.T.C."—the broker will go into action as soon as the stock hits 68.

Odd Lots

While the New York Stock Exchange is geared to deal in units of 100 shares, the machinery for handling small investors' odd lots has been greatly expanded. Today you can buy seven shares of stock almost as easily as a large trader can buy 700. These small transactions are carried out at the regular brokerage fee plus 12½ cents for each share of stock bought or sold. You must also pay the Federal tax.

A couple of other points are worth keeping in mind once you've opened an account. All orders you send the broker by mail or telegraph are automatically interpreted as good till canceled. You can cancel any order you've given your broker if it hasn't yet been executed, but be specific when you do. Such vague instructions as "Cancel my order in U.S. Steel," "Cancel my stops," "Sell my U.S. Steel," or "Cancel previous order and sell" can result in costly errors.

And don't ask your broker to use his own judgment in buying or selling stocks for you. Many a satisfactory arrangement has ended when "Use your own judgment" was substituted for a specific order.

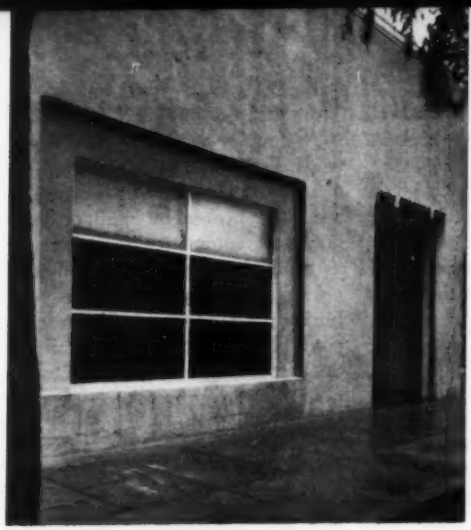
—EDMOND DU PONT

Innocent Bystander

• Mindful of possible legal entanglement, I always insist on having a third person present when I examine female patients. Late one afternoon, I motioned the last couple into the treatment room and tried to ferret out the woman's history of lower abdominal pain. Her answers were evasive. So, with the man looking on, I cajoled her onto the examining table and into the stirrups. When I made the first sign of being through, she jumped from the table with an agility I had seldom seen and fled from the room.

In surprise, I turned to the man at my elbow who I had assumed was her husband. His comment: "Can't be much wrong with a woman who runs like that. Who was she, anyhow?"

—M.D., MASSACHUSETTS



RED COLUMNS and green foliage relieve stark simplicity of main entrance.

A Compact Office for Ten Men

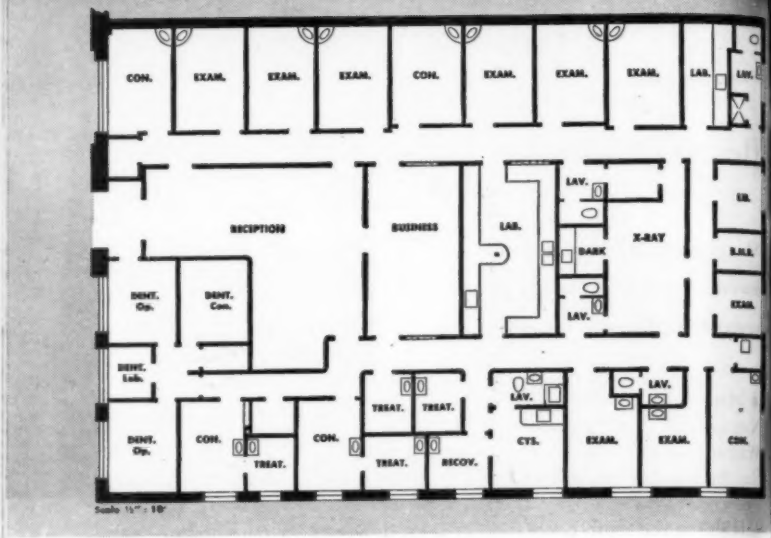
● Outstanding feature of the Beverly Hills (Cal.) medical building shown on these pages is its tightly-knit floor plan. Though the building contains less than 6,000 square feet of floor space, it provides private offices and complete laboratory facilities for nine physicians and one dentist. The structure was designed by Paul T. Frankl and Rollin Pierson. It was built in 1945 at a cost of $55,000.

Core of the building is a central section that contains the reception room, business office, diagnostic laboratory, X-ray room, and medical library. These facilities are used (and paid for) jointly by all ten practitioners, whose private offices are outside rooms separated from the central section by a U-shaped corridor. The design is functional, space-thrifty, and novel for private practice. (See floor plan, page 50.)

The reception room seats about twenty-five patients, but glass screens and furniture groupings are used to give visitors an unexpected degree of privacy. A glass partition separates the receptionist's working area from the waiting room. She uses a public address system, subdued in tone, to keep in touch with doctors in any part of the building.

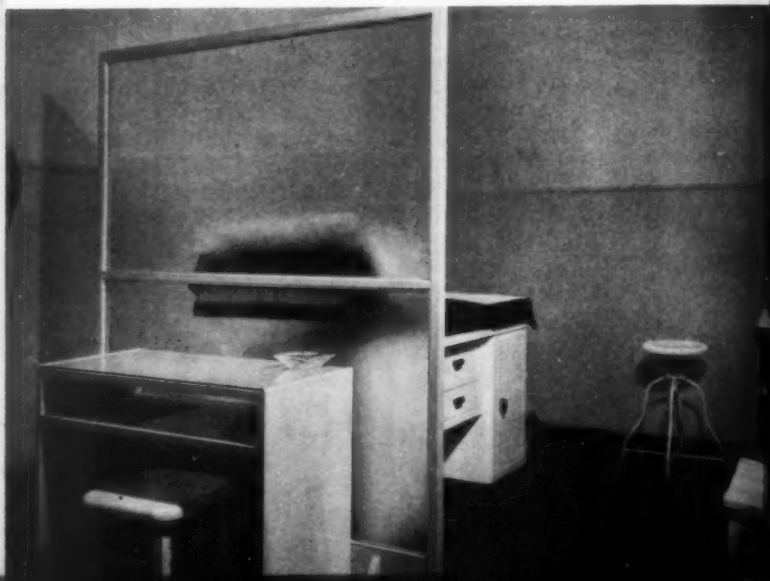
DAYLIGHT is the main decoration in suite designed for consultation without distraction. Rooms in building's central core have double skylights.

CHINESE MODERN decor is used in waiting room. Glassed-in cubicle at left houses receptionist, switchboard, and public address system.



EASY ACCESS to laboratory, X-ray room, and the other jointly-used facilities is provided by U-shaped corridor on which private offices face.

PATIENTS' PRIVACY is protected by opaque glass screens in examining rooms. Screens block unwanted glances from corridor when door is open.



Health Assembly Surprises Skeptics

Shows wide areas of agreement among medicine, labor, farm groups, and social agencies

• More than 800 delegates to the National Health Assembly met in Washington last month to help define the nation's health goals. Many a physician, remembering an earlier parley in 1938, had predicted that the Federal Security Agency's 1948 gathering would be similarly rigged for political ends. But rigged or not, the four-day talk fest ended with medicine's two-hundred-odd delegates agreeing that it had been a good thing.

The doctor's point of view got a thorough hearing before an attentive audience. Despite underlying disagreement on the issue of tax-financed medical care, the profession found itself eye to eye with labor, farm, and co-op participants on a wide range of points. The chief spheres of agreement were these:

¶ Voluntary prepayment plans offer the best means available at this time for improving the distribution of medical care.

¶ Physicians should be free to participate in all types of prepayment plans without imperiling their professional status.

¶ Under any prepayment plan, medical procedures and standards should be left to doctors.

¶ The Government should take a bigger part—financially and otherwise—in the nation's medical system.

¶ Serious shortages of medical personnel and facilities now exist.

¶ Vital statistics on U.S. medical resources are woefully incomplete.

New Report Due

Federal Security Administrator Oscar Ewing had been asked by the President to frame a ten-year national health program. The assembly was called to provide the FSA with specific recommendations. But Mr. Ewing made it plain that his report to the President, due sometime this summer, would reflect his own opinions and not necessarily those of the conferees. He has made plain, several times, his support of a Wagner-type program of compulsory sickness insurance.

Overall policy for the National Health Assembly was decided by a thirty-nine-man executive committee. Six of its members were physicians; a number were well-known laymen with only a token interest

The Man I Killed

● The practice of medicine is essentially a lonely one. Its severest trials usually take place in private; only the end results find their way into the public domain.

This would not be so if textbooks were more than a gross approximation of disease, or if the human animal did not assume such a contrary place on the statistical table. The 3 A.M. abdominal pain that is not quite characteristic of acute gastroenteritis nor of acute appendicitis is something the doctor learns about after medical school. In contemplating a course of action, he has to weigh all the intangibles. His own lack of sleep, the inability of the family to afford needless hospitalization – all the subtle nuances take part in this silent self-consultation.

Considering that an indeterminate quantity multiplied by an indeterminable quantity must yield a product whose range is even more variable, the high score of medical successes is something to be [*Continued on* 159]

in their assignment. The real work was done in the fourteen sections,* ten of which were headed by medical men.

The conference was privately financed and privately incorporated. Its $45,000 capital came from the American Red Cross, the Infantile Paralysis Foundation, the American Cancer Society, the Albert and Mary Lasker Foundation, the Milbank Memorial Fund, the Julius Rosenwald Fund, and similar agencies.

Why the private funds? "The FSA simply doesn't have the money," said Mr. Ewing. He added that "People on the Federal payroll are working for the assembly. There is a law that prohibits the use of Federal funds to influence legislation. The assembly should therefore pass no resolutions bearing on legislation before Congress."

That took the steam out of any scheme to put the assembly on record in favor of the Wagner bill. It did not, however, prevent the medical care section from featuring some debate on national health legislation.

Most of the discussion reflected a constructive tone. But there were exceptions, as when the AMA was baited with such barbs as these: The AMA favors a "charity or dole

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* There were sections on health and medical personnel; hospital facilities, health centers, and diagnostic clinics; local health units; chronic disease; maternal and child health; rural health; medical research; medical care; community planning; physical medicine and rehabilitation; dental health; mental health; nutrition; and environmental sanitation.

basis" of medical care. The AMA program is as "broad as it is narrow." The AMA attitude is "archaic," its slogans "worn and outmoded."

Most of the abuse came from union and co-op delegates. The co-ops accused organized medicine of making it difficult for them to get medical staff members. The AMA, they claimed, had also hedged on setting up standards for their approval. Union spokesmen labeled Blue Shield and Blue Cross plans "inadequate." They scored the preponderance of M.D.'s on the governing boards of the two organizations.

In the face of these charges, medicine's delegates kept their equanimity. Dr. Walter Martin, a member of the AMA Council on Medical Service, stated medicine's position thus: "Doctors are technically trained to say what's good medicine and what's bad. But they have no vested interest in medicine; they believe consumers should have a voice in prepay control. If anyone can propose a system to make medical care available to everyone and still preserve the quality of medicine, we are for it."

At one point, the tension was eased by a slip of the tongue. Nelson Cruikshank, director of social

"Tell him it's flatulence of the perimeter and charge him ten bucks."

insurance activities for the AFL, got his organizations mixed up. In the middle of a barrage against the AMA, he cried: "This situation comes about because of the obstructionist tactics of the American Federation . . ." The rest was drowned in laughter.

Despite such oratorical misses, the consumer groups worked well together to get their points on the record. At one juncture, a scheme was cooked up to get I. S. Falk of the Social Security Administration to the rostrum. Otis Brubaker of the United Steelworkers said: "A question was asked about medical care costs. I'm wondering if the section wouldn't like to have someone from the SSA present its figures." Mr. Falk, principal author of the Wagner bill, was present—and ready. But the section chairman, Dr. Hugh Leavell, ruled that only delegates could speak. Mr. Falk was not a delegate.

At another point, Dr. S. M. Greenberg of the Physicians Forum expressed surprise that delegates from the AFL, the CIO, and the Farmers Union had supported voluntary prepayment. The national organizations were already on record in favor of the Wagner bill, he pointed out. That opened the door; and Brubaker (CIO), Cruikshank (AFL), and Cole (Farmers Union) crowded through. They favored voluntary plans only while they couldn't get a Wagner program, they explained.

At the finish, both medical and lay spokesmen were able to agree on a number of recommendations. The ones having the widest implications for medicine were these:

1. "Voluntary prepayment group health plans embodying group practice and providing comprehensive service are the best available means at this time of bringing about improved distribution of medical care . . . Hence such plans should be

[*Continued on* 148]

In the Red

• Three months of practice had given me unbounded confidence in my surgical skill. Then one day I got a patient with a profusely bleeding finger. I stopped the hemorrhage and applied the dressing. Next, with a flourish calculated to impress the patient, I plunged my new scissors into the dressing and severed the bandage. Both patient and surgeon were astounded to see a gush of blood even more spectacular than the one just arrested. I had slashed my own finger almost a quarter-inch deep.

—M.D., CANAL ZONE

How the AMA House of Delegates Works

A revealing study of organized medicine's policy-making body, and what makes it tick

• A stiff dose of fine print in the Journal AMA next month will let physicians know that their elected policy-makers, the AMA delegates, have met again. How many medical men will actually sift through the proceedings of the house remains a moot point. But chances are that a number will risk eyestrain to find out what went on.

Which is natural enough. For the welfare of the practicing M.D. hinges largely on the actions taken at these semi-annual sessions. All of organized medicine's legislative powers reside in the House of Delegates. What's more, the delegates elect the men who watch over the profession's affairs between sessions: the general officers of the AMA.

In practice, these sweeping powers are watered down a bit. The house depends on the AMA Board of Trustees for funds, and the two groups don't always see eye to eye on where the money should go. This situation has drawn a mite of head-shaking from the lower echelons. Some years back, the editor of the Westchester (N.Y.) Medical Bulletin pointed out that "the trustees are not obliged to act on any motion from the house involving the expenditure of funds* . . . As long as this obtains, the House of Delegates should be called the Q.P.F.—Quintessence of Political Futility."

This is, of course, an obvious exaggeration. It is recognized as such by the men who today contest vigorously for the job of delegate. They realize that (in the words of one house member) "through the delegate, members of state and county medical societies have their most important avenue of self-expression on the national scene. By his actions will all of medicine be praised or damned."

House Physicians

The 175 men who hold these jobs are all AMA fellows who have been elected for two-year terms. They represent fifty-three state and territorial medical societies; eighteen scientific sections of the AMA; the Army, Navy, and PHS. State soci-

* As the AMA by-laws put it: "All resolutions or recommendations of the House of Delegates pertaining to the expenditure of money must be approved by the Board of Trustees before the same shall become effective."

eties are represented in proportion to their active memberships. Thus, New York has twenty delegates, Pennsylvania ten, Illinois and California nine each. Sixteen states rate just one delegate apiece. So do Alaska, Hawaii, Puerto Rico, the Canal Zone, the scientific sections, and the Government services.

What sort of men comprise the AMA House of Delegates? To find out, this magazine analyzed the roster of delegates to last year's centenary session—with some interesting results. Here's what the study showed:

PRESIDING OFFICERS: Roy W. Fouts (left), Omaha radiologist who has served as speaker of the house since 1946, is a veteran of twenty-four house sessions. Another radiologist, Francis F. Borzell of Philadelphia (above), is heir apparent to the gavel-wielder's job. He has been a member of the house since 1936, the current vice speaker.

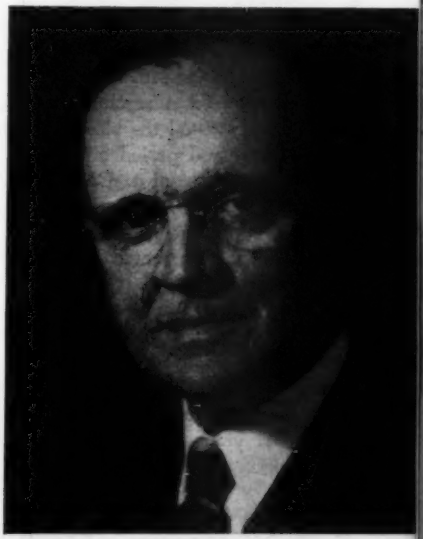
The average delegate limits his practice to a specialty. He comes from a town of more than half a million population. He is attending his seventh session as an AMA delegate. He is sixty years old and inclines toward the conservative viewpoint.

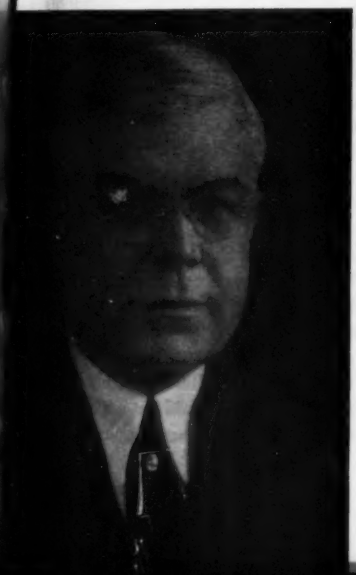
Fewer than a dozen house members are out-and-out general practitioners. All the rest are full or partial specialists (except for two

listed as "not in practice"). A whopping 67 per cent of the delegates limit their practices to specialties, as opposed to 31 per cent among all active, private practitioners in the country.

Almost as scarce as G.P.'s are men from small towns. The centennial roster shows a handful of men like Dr. George A. Woodhouse of Pleasant Hill, Ohio (population 738) and Dr. James Beebe of Lewes, Del. (population 2,246). But the census count on the average delegate's home town adds up to 577,000.

A turnover of some 25 per cent a year in house membership has failed to dislodge a number of long-time delegates. Most familiar face of all belongs to Dr. Arthur J. Bedell, delegate from the Section on Ophthalmology, who has taken part in thirty-two house sessions. Other delegates with enough tenure to shake a stick at include the five men listed on the following page. Since the house convened only once a year until 1946, each of these





ELDER STATESMEN in the house include Arthur J. Bedell (below) of Albany, N.Y., who has been a delegate for three decades. Another senior delegate is Walter F. Donaldson (right) of Pittsburgh. He played a leading part in the 1938 special session called to formulate medicine's policy on a national health program.

physicians thus began his career as a delegate at least two decades ago:

	Sessions Attended
Burt R. Shurly, ALR section	28
W. F. Donaldson, Pennsylvania	24
Roy W. Fouts, Nebraska	24
H. B. Everett, Tennessee	23
Thomas F. Thornton, Iowa	22

The hackles rose on some of these men in January 1948, when Colorado introduced a resolution that would have tossed the oldsters out after a specified period of service. But nothing came of it. Goaded by some tart remarks from the senior delegates present, the house decided the matter should be left to the states.

The delegates' age—the median is 60, as opposed to the all-physician age median of 47—has led to some querulous comments about the representativeness of the system. "If you want to understand the workings of the House of Delegates," one critic has said, "just stand in the back of the room and count the bald heads."

A more polite pundit, Delegate Herbert P. Ramsey of the District of Columbia, has written: "There is some doubt whether the younger men can or should look to men in the upper age group for action. After all, their economic security has been attained. The changes now in process cannot affect them or their patients for very long."

Three years ago, AMA President Roger I. Lee took notice of these murmurs of discontent. "Perhaps the most adverse comment on the American Medical Association," he said, "relates to insufficient infusion of young blood in the House of Delegates. The remedy does not lie in the house, but in the constituent associations."

Acting on this cue, several state societies have since engineered something of a youth movement in their AMA delegations. Chief among them: Oklahoma, whose two-man team at the centenary session averaged 52 years. Ohio and California have the youngest of the large delegations today; Ohio's averages 53, California's 54. Connecticut and the District of Columbia are other regions represented by men considerably younger than the house average of 60. Junior delegate at the 100th-year meeting was Vermont's Theodore H. Harwood, a 36-year-old internist.

The growing accent on youth

How to Get in Touch With Your Delegates

AMA delegates are authorized to bring up any business, new or old, that they feel warrants discussion in the house. AMA members who would like specific issues raised or specific viewpoints expressed can reach their own delegates via telegram at any house session. During this month's AMA meeting, June 21-25, simply wire: Delegates from (name of your state), Delegates' Registration Desk, American Medical Association House of Delegates Meeting, Palmer House, Chicago, Ill.

may in time help to dispel criticism that the house as a whole doesn't represent the average physician. Meanwhile, a more valid criticism is directed at delegates in the top age bracket, whose interests and energies sometimes fall short. Consider, for example, the ages of the twenty senior physicians in the house:

84	76	74	73	71
79	75	74	73	71
79	75	74	73	70
77	74	73	72	70

The southern medical societies send delegates substantially older than the rest. For example: Maryland's representatives average 78 years of age, Tennessee's 68, Alabama's 67, Georgia's and Texas' 66. Senior man in the house during the centennial session was 84-year-old George P. Johnston, the one-man delegation from Wyoming.

All this has long been reflected in the political tenor of the house. But though men of conservative leanings still hold the reins, a shift to the progressive side is under way. The changing sentiments of medicine's policy-makers can best be observed by checking past house actions.

In 1934, for example, the house resolved: "The immediate cost [of medical service] should be borne by the patient able to pay at the time service is rendered." This doctrine, if adhered to, would have squelched prepaid medical care for good.

And in 1937, AMA delegates de-

cided on a policy of "passive receptivity" anent a national health program. This virtually invited the Government to formulate such a program on its own—which it promptly did.

Both these stands would win only minority support in today's House of Delegates. Though the AMA is still accused of "peddling horse-and-buggy medical economics," the charge doesn't jibe with the delegates' current interest in bigger and better prepay plans, in positive health legislation, in group practice, in indigent care, and in medical preparedness. Translating interest into action may remain a slow process as long as the *status quo* element retains its strength. But most observers see that strength dwindling.

For a specific count of the house's political pulse, some men point to the vote for speaker the last time the election was contested (1946). One nominee was California's Lowell S. Goin, who, in his own words, has "frequently opposed Doctor Fishbein and the policies of the trustees." The other nominee was Nebraska's Roy W. Fouts, whose views are generally conservative. Doctor Fouts was elected by a vote of 90-77, as good an indication as any of the conservative-liberal pow-

"I've got to grab a bite and run, dear. Don't fix anything special."

er balance at that particular time.

Says one leading delegate: "Changing the political complexion of the house takes time. First, the county societies send forward-looking men to their state society sessions. Then, after a few years, the state societies elect similar men to the AMA House of Delegates. I believe the day is not far off—perhaps even this year—when the younger and more progressive delegates will win out in the AMA."

Though the house's political spirit has often been challenged, its efficiency seldom has. So smoothly are house sessions run that the American Bar Association has, on occasion, sent observers to see how it was done. Most of the credit for this hot parliamentary pace belongs to the presiding officer. The current speaker, Roy Fouts, learned much of his art from his predecessor, Harrison H. Shoulders of Tennessee. The current vice speaker, Francis F. Borzell of Pennsylvania, can be counted on to keep up the high standard if, as expected, he succeeds to the gavel-wielding spot.

Each time they meet, the delegates are faced with the superhuman task of doing half a year's work in two or three days. They follow a schedule that is stripped for action. Nominating speeches, for example, are limited to two minutes apiece, so that most of the vote-winning for trustee and presidential candidates must be done after hours.

* HANDITIP *

Wall Cabinet

The lavatory in my office opens on the reception room, and patients used to be embarrassed when they'd have to cart urine specimens through an often crowded room. I've eliminated the red faces by installing a two-way double-door shelf in the wall between the lavatory and my laboratory. Now the patient sets the specimen glass on the shelf, then I open the door on my side to get it. —M.D., NEW YORK

* * * * *

Most important cogs in the house machinery are the dozen-odd reference committees appointed by the speaker at the beginning of each session. To them the speaker channels old and new business introduced by delegates on the house floor. The appropriate reference committee stages off-the-floor hearings on each piece of business, then makes its recommendations to the house as a whole. The house is usually inclined to accept what the reference committee recommends. Debate is frequent, but reversals are few.

Reference committees of most significance to practicing M.D.'s are probably those on (1) medical service; (2) legislation and public relations; (3) executive session; (4) reports of trustees and secre-

tary; (5) reports of other officers; (6) medical education; and (7) miscellaneous business. To each committee the speaker appoints five or more delegates, one of whom he designates as chairman.

Key appointments seldom go to untested men. Theoretically, a delegate could expect to win a reference committee chairmanship about every thirteenth session. But the following delegates have been named to important chairmanships at least two sessions out of the last four:

William Bates of Pennsylvania
W. G. Phippen of Massachusetts
Edwin S. Hamilton of Illinois
Charles H. Phifer of Illinois
Creighton Barker of Connecticut
O. W. H. Mitchell of New York
James R. Reuling of New York
W. A. Coventry of Minnesota
Elmer Hess of Pennsylvania
Wingate Johnson of North Carolina

Also theoretically, a delegate could expect to be appointed to some reference committee every second or third session. But the following men (plus some already listed) have been named to reference committees at least three sessions out of the last four:

Allen H. Bunce of Georgia
L. S. McKittrick of Massachusetts
Thomas P. Murdock of Connecticut
Walter P. Anderton of New York
Raymond L. Zech of Washington
D. G. Smith of New Hampshire
Thomas A. Foster of Maine
E. Vincent Askey of California
John W. Cline of California
Lowell S. Goin of California

Which would indicate that these twenty men have had more to do with shaping recent AMA policies than most other members of the house.

The fact that familiar names keep cropping up on committees that do the bulk of the work has led to some criticism. But the practice is of long standing. Harvard University's Oliver Garceau, who kept score on the most important AMA reference committees for a ten-year period, found that 5 per cent of the delegates available for appointment received 43 per cent of the appointments dealt out.

A more serious charge heard occasionally is that delegates' committees are loaded to favor the conservative, or "headquarters," viewpoint. An alleged example: At the January 1948 session, the house decided it should investigate interne distribution. A dissenting minority held that this was a job for AMA headquarters. When the investigating committee was finally appointed, members who had opposed the original resolution were found to be in the majority. No strong supporters of the idea were named to the committee that would follow it through.

As one executive secretary has

[*Continued on* 154]

DEATH'S HEAD held by Doctor Daley isn't really there at all. Man who took picture says it's not a double exposure, either—just another illusion in the Daley repertoire.

PRESTIDIGITATOR

CLOSE UP

In the days when people believed that magic was good for what ailed them, every doctor worthy of the name had to know his "abracadabras" from A to B. "I guess I'm just a throwback to the old tradition," says Jacob Daley, a New York plastic surgeon whose mastery of the conjuror's art has brought him a reputation as one of the nation's leading sleight-of-handers.

The doctor is an amateur magician whom professionals gather to watch. He originally appropriated magic as an antidote for tension and

overwork. "I just picked it up," he explains. "Now I can't put it down."

Blatta Orientalis

Like all good tricksters, he regards magic as an art with strong dramatic possibilities. During a recent performance of his much-requested "cups and balls" illusion, in which the balls pass mysteriously from cup to cup, he kept murmering a strange incantation: "Blatta orientalis," he repeated solemnly, his eyes half-closed, "Blatta orientalis." The audience watched spellbound. Later someone asked him what the exotic chant meant. He grinned impishly: "Blatta orientalis," he said, "is the scientific term for cockroach."

Smart people, he finds, are the easiest to fool. Not long ago a group of Oak Ridge scientists watched him do a card trick that was—according to his description—"so simple a small boy could master it with an hour's practice." The routine was repeated a number of times almost under their noses, but the baffled atom busters were unable to explain it. "Looking for a complicated answer," says Jacob Daley, "they shut their eyes to the obvious."

His surgeon's fingers slip in and out of a deck of cards like fish through water. But mere manual dexterity, he feels, is not so important to successful deception as the proper mental and psychological approach. A running patter of commentary makes his mind-reading demonstrations so convincing that members of the audience often refuse to believe he doesn't have a direct wire to the Great Beyond. To heighten realism, store-bought props are kept to a minimum.

"Working without props is a challenge," he says. "Like performing a brain operation with only a pen-knife."

Tip Seekers

A graduate of the Fordham University School of Medicine, 50-year old Jacob Daley is associate attending in otolaryngology at New York City's French Hospital. Though he occasionally performs a few tricks for colleagues or for patients who need cheering, most of his conjuring is done before professionals and advanced amateurs like himself.

It's professional criticism, he feels, that keeps a prestidigitator in the pink. "Good magicians appreciate the nuances, the beauty of a trick," he says. "The ordinary audience is just looking for a laugh."

A routine much in demand is the Daley demonstration of maneuvers, subtleties, and dodges used by professional gamblers in bilking the unwary. Often, he finds, when the exhibition has been concluded, people otherwise honest and trustworthy beg for confidential pointers on how to cheat at poker.

"I always refuse," he says with a wink. "The conjuror's code, you know."

SWINGMASTER

CLOSE UP

Dr. George Washington Davis, age 80, of Ottawa, Kan., is the acknowledged peer of U.S. pendulum builders. A specialist within a highly specialized field, he has spent more than fifty years perfecting that rarity among pendulums, the phenomenal Foucault.

Chief difference between the Foucault and run-of-the-mill pendulums, the doctor explains, is that a gentle push sets it swinging for hours of its own momentum. Because it maintains its original plane, independent of the earth's rotation, it represents "the purest form of motion." "With my Foucault," says George Davis expansively, "I can feel the pulse of the universe."

Only twelve such pendulums now exist anywhere in the world. Doctor Davis has built three of them, has assisted in the construction of several others. Most are centers of attraction on university campuses, where they are used to teach science students.

Invented almost 100 years ago by a French physicist, the Foucault pendulum demonstrates mechanically—in case there are still any doubts about it—that the earth really rotates. People have long recog-

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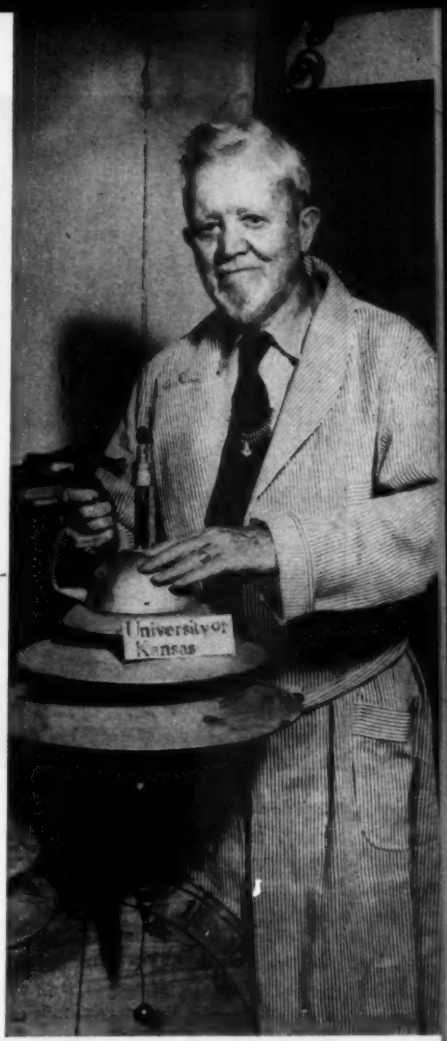


PLAY is George Davis's word for the complicated calculations that go into the construction of one of his time-telling Foucault pendulums.

PLANT-PICKLING doctors, Sidney and Philip Joffe, display carnations on which their preservation process has just been completed.

MUMMIFIERS

CLOSE UP

Archaeologists of some distant era digging through the relics of Twentieth Century civilization may be amazed to find cut roses, orchids, and other flowers blooming brightly in the rubble. They'll be amazed, that is, unless they've already heard about the Joffe discoveries in tissue preservation. For two after-hours inventors named Philip

and Sidney Joffe, twin M.D.'s of Paterson, N.J., have perfected a method for preserving the beauty of an orchid long after the glamor girl who wears it has become a gray-haired grandmother.

Second-Hand Rose

The Joffes began their experiments while still medical students at New York University's College of Medicine. Their uncle had conducted considerable research in the preservation of paper, and the idea caught the twins' fancy. Quarts of midnight oil went up in smoke as the three of them worked away in a makeshift laboratory.

One evening, a rose was accidentally dropped into the paper preservative. It was plucked out, cast aside, and forgotten. Days later the rose was discovered intact and unwilted—and the twins knew they had hit on something big.

Today the brothers, aged 39, work as a team on their experiments, which they regard strictly as an avocation. Their teamwork carries over into medical practice: Sidney is a surgeon, Philip an internist, and they share the same office.

Reminiscent of ancient Egyptian embalming methods, the patent-protected Joffe formula is based on three simple dipping operations. The first fixes color, the second holds the form, the third seals the surface against moisture and bacteria. Not only does this mean a lifetime guarantee for milady's corsage; small animals, birds, even human tissue can be preserved in exactly the same way.

At the core of the twins' twenty-year experimentation has been the struggle to hold color. For a long time, white, red, and green resisted all their efforts. White became yellow and red turned brown. "We had to find exactly what produces color before we could lick that problem," says soft-spoken Sidney Joffe. As far as the twins know, theirs is the first mummifying method that preserves color as well as form.

Lately the Joffes have been deluged by inquiries from foreign nations that want help in eradicating plant disease. The new process, it seems, arrests and preserves blight along with the rest of the flower, thus making possible a more intense study of plant disease than ever before. The American Museum of Natural History is also looking into the possibilities of Joffe-preserved flora for its exhibits.

No Use Sniffing

Will flowers that last forever cut down the demand for fresh blooms? The twins don't think so. "There's just one thing our bouquets lack," says Sidney Joffe; "that's fragrance. Most people aren't satisfied to look at a rose. They insist on sniffing it, too." So far, the two doctors haven't figured out a way to wrap up the smell for the next century.

'Grand Jury' Hears Discipline Cases

How one state medical society is clearing up charges of 'unprofessional conduct'

● A western experiment in professional self-discipline has come through its first six months with flying colors. Some twenty-five cases of alleged professional misconduct have been filed with the board of supervisors or "grand jury" of the Colorado State Medical Society (many more were predicted). Most of the cases have been settled amicably, without lawsuits or screaming headlines. At the same time, the board has conducted a vigorous preventive campaign that has reached every doctor in the state.

When cases can't be settled amicably, the twelve-man board is empowered to crack down. Two of its earliest cases were referred to the state board of medical examiners with requests that licenses be canceled. Two others were routed back to county medical societies with strong recommendations for discipline. At the same time, the board has lived up to its advance billing as "a formal method for heading off the kinds of trouble that have a serious effect on what the public thinks of the profession."

The board was set up last fall by Colorado medical men, partly in answer to the charge that "doctors will go to any lengths to protect the incompetent or unethical colleague." It investigates written or verbal complaints against any Colorado doctor, whether a state society member or not. Such complaints originate from patients and from physicians. They stem from minor misunderstandings, serious malpractice, and most everything in between.

The Colorado supervisors conduct hearings in strictest confidence. No one except the physician-members of the board and the witness being heard is admitted to any part of the proceedings. All testimony stays off the record. A board member is disqualified from sitting on a case if it concerns a physician within the jurisdiction of his own county medical society.

After both sides of a doctor-patient dispute have been heard, the supervisors decide on the best way to adjudicate it, then hand down their recommendations. If a physician is deemed guilty of unprofessional conduct, the board may prosecute the case before the proper judicial body—*e.g.*, a component

society's board of censors, the state society's board of councilors, the state board of medical examiners, or a criminal court. The supervisors don't file charges without first checking their evidence with the state society's attorney.

About half the cases handled so far have involved "overcharging." When this complaint is justified, the board recommends a fee adjustment. Most such complaints, though, have stemmed not from unfair fees but from the physician's failure to explain laboratory, X-ray, or other extra costs. Thus unprepared, the patient is understandably jolted when he gets the bill.

Most complaints are made in good faith. The supervisors have had remarkably little difficulty with cranks. But the board often serves to defend physicians against false or exaggerated accusations. Consider, for example, this case:

A woman was seized with pains in the abdomen while she and her husband were out driving one Sunday afternoon. The husband complained that he called several doctors from a filling station, but could get no one to attend her. On checking, the board found that the "several doctors" had totaled two, one of whom had been out of town. The other had been up all night on an

"Then you would say, Doctor, that except for these things the deceased was in excellent health?"

O.B. case. This physician had given the man what he considered the most expedient advice: that he drive his wife to the hospital at once. The doctor had erred only on the side of brusqueness, the board decided. It cautioned him accordingly.

A more serious case was that of a doctor en route to a hospital with an acute surgical case: He had stopped off on the way to do a number of personal errands. After hearing both sides of the story, the supervisors relayed it to state licensure officials—with a request for revocation of the doctor's right to practice in that state.

In scotching the practice of rebates, the board didn't wait for individual complaints. Each county society was asked to enforce "immediate disciplinary measures against each and every one of your members who are accepting rebates, whether they be from optical manufacturers or dealers, instrument or brace makers, laboratories or drug firms." The societies were instructed to name names whenever they discovered offending doctors.

The Colorado board deals with prevention as well as cure. It puts out periodic educational bulletins based on its first-hand experience as an intermediary between the profession and the public. Some sample words to the wise:

"Do you explain clearly to patients consulting you the need for laboratory work, its cost, and the probable total fee to be rendered? Are you sure the patient *understands* what you have told him? . . .

"Do your records tell the exact story of the history given to you and the findings you observed? Some of the men accused before the board presented such complete records of their cases that our board was able immediately to reject the complaint as not justifiable . . ."

To discourage malpractice suits, the board has conducted a "Watch Your Speech" campaign. Members were cautioned to beware of encouraging a patient in his complaints against a physician who had given him prior treatment. Warned the board: "It is easier to cause trouble than to cure it."

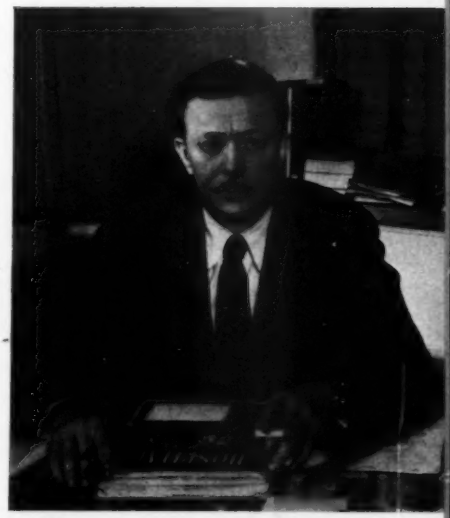
An "Explain Yourself" campaign was also carried on. It emphasized that the patient seldom stops to realize the doctor is overworked and crowded for time. Unless the physician spends a few moments explaining why he's been delayed, the board pointed out, the patient may feel merely that he's being pushed around.

There have been some mutterings among doctors that the board's discipline is a "stiff dose." But the majority reaction is that hearings have been marked by integrity and fairness. The board makes it clear that it depends not on strong-arm methods but on cooperation from member physicians. Today it is getting that cooperation in full measure.

—JOHN BYRNE

Rural Areas Getting New Hospitals

Go sign for construction under Hill-Burton Act given to 160 high-priority areas



CHIEF of the PHS Hospital Facilities Division is Dr. Vane M. Hoge, author of this report on how the Hill-Burton Act is being carried out. Readers will find some disturbing implications in what he says.

●Four out of every ten counties in the U.S. today have no registered hospitals. That striking deficiency was in many a Congressman's mind twenty months ago, when he voted for what he hoped would be the legislative remedy. Today I can report that the remedy—the Hill-Burton Hospital Survey and Construction Act—is beginning to work.

What's more, the intent of Congress to fill rural needs first is being fully carried out. Some 160 applications for hospital construction have already been approved; of these hospitals-to-be, sixty-three are earmarked for towns of less than 2,500 population. Another thirty-three are slated for towns of 2,500-5,000.

More than 80 per cent of the proposed new hospitals approved to date are general hospitals. They are all relatively small, averaging about fifty beds, costing around half a million dollars apiece. Only about a dozen of all the hospitals authorized so far under the Hill-Burton Act have over 100 beds.

Thus, the two main purposes of the act are being realized:

First, construction will soon start on hospitals and clinics in areas where they are critically needed. Beds, operating rooms, laboratories, and other hospital facilities will be

brought to communities that have long been without even the most basic services.

Second, more doctors, nurses, and technicians, will soon migrate to these deficit areas. Modern medicine demands modern facilities with which to practice. No hospitals . . . no doctors . . . no health care. Stripped down, the situation is almost that simple—and that bad—in some parts of the country.

The Hospital Construction Act is primarily a local program rather than a Federal one. Every participant must finance two-thirds of its construction with local funds. Only one-third comes from Federal grants. A number of states have already made appropriations to supplement Federal allotments, and this will help many poorer communities raise their construction funds.

In spite of the difficulty of raising two-thirds of the local funds in areas of greatest need, it appears that the first two or three years' allotments in most states will be taken up by relatively poor communities. But this highlights several weaknesses in the act that merit correction:

1. The act provides no funds for maintaining hospitals after construction. It will undoubtedly be difficult for many needy areas to give reasonable assurance that they will be able to operate their hospitals, even though they may be able to raise the initial funds for construction.

2. In those states where there is no provision for state grants-in-aid, it is inevitable that many communities will be unable to benefit under this program.

3. It was recognized from the start that the present five-year program could reach but a small percentage of our total need. State surveys now completed show this to be less than 15 per cent. If the aims of the act are to be realized, the program must be considerably extended. —VANE M. HOGE, M.D.

Short-Winded

● Before starting a post-mortem, we decided that a chest X-ray was called for. The cadaver was wheeled to the X-day department and propped up under the technician's supervision. She was about to make the exposure when, from force of habit, she stuck her head out from behind the control panel and called: "All right now, take a deep breath and hold it."

—M.D., NEW YORK

How the New Tax Law Affects You

Here are the best ways to save money under Federal income tax provisions for 1948

• Congress has done its bit to restore the long-dormant theme, "Two can live as cheaply as one." It has turned this trick by passing, over Presidential veto, a tax reduction law that will save doctors—along with many others— a pretty penny in 1948.

The new law reduces individual income taxes by increasing permissible deductions and exemptions, by lowering tax rates, and—most important of all—by allowing husbands and wives to split income. Let's take up these points in order and see how they affect the average M.D.

The personal exemption and credit for each dependent has been increased from $500 to $600. If in 1947 you were single and claimed your two parents as dependents, your personal exemption and credit for dependents amounted to $1,500. Under the same conditions in 1948, you'll be allowed to lop $1,800 off your taxable income. (The law still defines dependents as close relatives with gross incomes of less than $500, who receive more than half their support from you.)

Two new kinds of exemptions are authorized by the 1948 law. First, any taxpayer who attains the age of 65 by the last day of the taxable year is allowed an "old age" exemption of $600. Thus, if you and your wife have both reached 65 by Dec. 31, 1948, you are entitled to $1,200 of "old-age" exemptions on your joint return. Since this is over and above your personal exemptions of $1,200, that makes a tax-free total of $2,400. (No additional exemption is allowed for dependents who are 65 or over.)

Deduction Boost

The second new exemption is an allowance of $600 for persons who are blind. This exemption, where applicable, is added to the others described above. It applies only to the taxpayer and his spouse, not to dependents.

Changes have also been made in allowable deductions. In 1947, if your adjusted gross income (professional net income, dividends, interest, etc.) was at least $5,000, you were permitted to use a standard deduction of $500 instead of itemizing everything. For 1948, this standard deduction has been in-

TABLE 1

MAXIMUM MEDICAL DEDUCTIONS ALLOWED

Type of Return	Personal Exemptions	Maximum Medical Deduction 1947	1948
Separate	1	$1,250	$1,250
Separate	2 or more	2,500	2,500
Joint	2	2,500	2,500
Joint	3	2,500	3,750
Joint	4 or more	2,500	5,000

creased to $1,000 or 10 per cent of your adjusted gross income, whichever is less. (But if you have $5,000 or more of adjusted gross income, are married, and still file a separate return, your standard deduction remains $500.)

In the case of married persons filing separate returns, both must use the standard deduction or both must itemize all their deductions.

It is still good policy to list your deductions separately, then compare the total with the standard deduction. Thus, you'll be sure to use the method that produces the smaller tax. Obviously, if your deductions for interest, contributions, taxes, etc., total $1,200 in 1948, you'll want to itemize all deductions on your tax return, since the maximum standard deduction you can use amounts to only $1,000.

The new law has increased the maximum amount deductible for medical expenses. However, you still get no tax benefit for such expenses that are less than 5 per cent of your adjusted gross income. Table 1 compares the maximum amounts deductible in 1947 with those permitted under the new law.

What about overall tax rates? The 1947 law allowed you a percentage reduction of 5 per cent in your tax after all other computing had been done. This has been replaced by allowable reductions ranging from 9.75 to 17 per cent. The average doctor—whose tax before reductions is between $400 and $100,000—will reduce his tentative tax by 17 per cent of the first $400 plus 12 per cent of the remainder.

Table 2 translates this into actual tax dollars for an unmarried M.D.

Now let's look at the new tax provision that will save most doctors the most money: the "split income" provision.

Prior to 1948, married people in "community property" states were permitted to divide their "community income" between them. They could then file separate returns and materially reduce income taxes.

To illustrate: Suppose that in 1947 your wife had no income and your taxable income (after deductions and personal exemptions) totaled $8,000. Disregarding the 5 per cent reduction applicable in 1947, your Federal income tax would have been $1,680 in a community property state. In any other state, it would have amounted to

TABLE 2

TYPICAL INDIVIDUAL RETURNS

FOR 1947 AND 1948

	1947	1948
Adjusted gross income ..... (professional net income, dividends, interest, etc.)	$9,000	$9,000
Less: standard deduction	500	900
Net income	8,500	8,100
Less: personal exemption	500	600
Taxable income	8,000	7,500
Tentative tax	1,960	1,810
Less: percentage reduction		
On $1,960 @ 5%:	98	
On $400 @ 17%: $ 68.00		
On $1,410 @ 12%: 169.20		237.20
Net tax to be paid	$1,862	$1,572.80

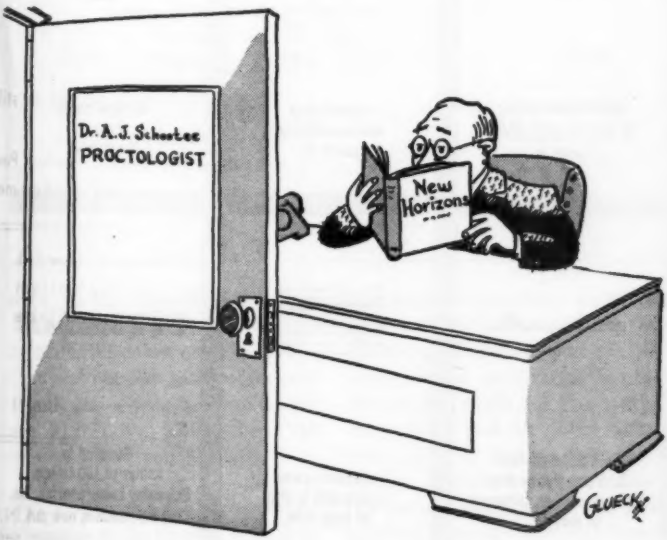
$1,960. Thus, the mere fact that you lived in one state instead of an other meant $280 difference in your Federal income tax bill.

Happily, Congress remedied the situation as of Jan. 1, 1948. Regardless of what state you live in, you now have the option of splitting all income between husband and wife, then computing your tax at the lower surtax rates. Even those married persons who live in community property states get some benefit from the new law: *All* income may now be split, instead of just "community income."

To take advantage of this new provision, you must file a joint return with your spouse. Then follow this simple, step-by-step procedure:

1. Add up both persons' incomes to arrive at a combined adjusted gross income.
2. List your combined deductions, then subtract them from adjusted gross income.
3. From the resulting net income subtract the combined personal exemptions and credits.
4. Divide the result by two.
5. Apply the tax rates to this amount to arrive at a tentative tax.
6. Reduce the tentative tax by the percentage reductions effective for 1948.
7. Multiply the result by two. This is the total joint tax to be paid.

Table 3 illustrates how this



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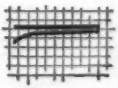

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TABLE 3

TYPICAL JOINT RETURN

FOR 1948

Your adjusted gross income	$10,000
Your wife's adjusted gross income	1,000
Combined adjusted gross income	11,000
Less: combined deductions	1,800
Combined net income	9,200
Less: combined exemptions	1,200
Combined taxable income	8,000
Combined taxable income divided by 2	4,000
Tentative tax on $4,000	840
Less: percentage reduction	
On $400 @ 17%: $68	
On $440 @ 12%: 52.80	120.80
Result	719.20
Result multiplied by 2:	
Your total joint tax	$ 1,438.40

works. In the example given, your 1948 tax would be $1,438.40. Under similar circumstances in 1947—if you did not live in a community property state—your tax would have been $1,871.50. Thus, the 1948 law would save you $433.10.

What should you do about it now? You should file an amended declaration at the time of your next quarterly tax payment. In this way you can avoid overpaying your 1948 tax. Of course, you can allow your present declaration to stand, then claim credit for the overpayment when you file your 1948 return (on or before March 15, 1949). But this latter procedure is not recommended unless the saving involved is small.—ALFRED J. CRONIN

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Medical Co-ops Claim New Gains

New health cooperatives are springing up as national agency gathers momentum

• The cooperative health movement, object of some low esteem and high suspicion among physicians, appears to be burgeoning. "More than fifty medical co-op groups from Nova Scotia to California have started organizing in the past year and a half," estimates Dr. Michael A. Shadid, acknowledged leader in the co-op field.

To which the Cooperative Health Federation adds these details: "Thirty medical co-op groups are now operating; fifteen more are incorporated but are not yet giving service; about twenty others are in some stage of organization."

Just how many patients belong to health co-ops is a matter of speculation. But it appears that the total has jumped in the past year or two. According to the Social Security Administration, the number of people cared for in 1945 by co-op clinics and hospitals was 350,000. In the same year, says the SSA, more than a million people were enrolled in co-op prepay plans.

Today, a partly completed AMA survey lists 169 cooperative prepay plans in forty-two states. In sixty-two plans alone, 1,028,853 persons are enrolled. The AMA has no figures on co-op clinics or hospitals.

Besides the growth of the health co-ops, three other trends are worth noting. According to Doctor Shadid, these are:

¶ A preference among both rural and urban co-op groups for health center programs rather than for hospital programs. (This is traceable in large part to current high construction costs.)

¶ A resulting emphasis on preventive and ambulatory care.

¶ Continued difficulty in recruiting enough doctors for co-op medical staffs.

Physician Pinch

Co-op leaders hope to ease their physician shortage through the Cooperative Health Federation. The CHF was born two years ago at a meeting of farm, labor, and medical co-op representatives. The birth was accompanied by considerable howling against organized medicine —so much so, in fact, that no one got around to defining the aims of the federation.

Now, however, the CHF sees a clear-cut, dual mission. Its prime

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objective is aid for new co-ops. The CHF will not, it says, seek new legislation (though it will lend legal talent to those who do). Nor will it give financial help to individual co-ops (though it will supply consultants on such problems as fund raising, finding staff physicians, etc.). The federation also hopes eventually to establish minimum standards for co-ops.

The question of medical standards has worried the CHF since its beginning. Says a spokesman: "We asked the AMA to set up standards. We believed the AMA survey would lead to a set of standards. That has not happened yet. Although we hope for results in the next year or two, we are not optimistic."

The AMA replies, in effect: A number of cooperatives have not yet supplied full information; no data, no standards.

Meanwhile, the CHF is planning to set up its own code. It feels co-ops must meet essential requirements if they are to help with the federation's second declared objective: to stand off a Wagner-type national health program. The federation has no concrete scheme for doing this. But it thinks consumer participation in the control of medical services will win people away from a nationalization plan.

But if co-ops are to siphon off

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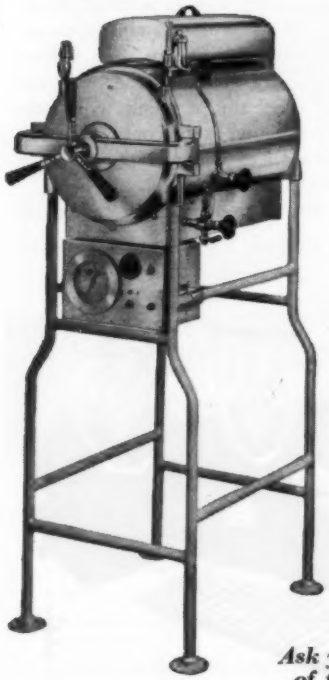

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Wagner plan supporters, they'll have to grow a lot faster. On this score, the CHF hopes other states will note a new enabling law in Wisconsin. "Already," says Doctor Shadid, "fifteen communities in that state are setting up co-op medical prepay plans."

Key features of the Wisconsin law, which got backing from the state medical society, are these:

¶ Co-ops must make available to members both medical and dental care.

¶ Co-ops must provide at least one physician and six hospital beds for every 2,000 members.

¶ Hospitals may not discriminate against physicians who participate in a co-op plan.

¶ Co-ops may contract with any existing hospital in the state.

Though the co-ops are making headway with the public, they cling to basic ideas that have caused doctors to remain unfriendly to them. The co-op attitude on compensation of physicians, for example, is hardly conducive to winning large numbers of medical friends. Witness Doctor Shadid's account of an S.O.S. he received from two Texas co-ops:

"Both hospitals were going in the red each month," he says. "In each instance, the cause was compensation of physicians on a fee basis. It was plain that a salary or capitation system would have caused no difficulty. Only these methods can keep a prepay fund solvent and prevent chiseling on the part of some physicians."

Medical men are likely to appreciate the co-op attitude less when they look at the balance sheet of the Elk City Community Hospital, star performer in the co-op field. How can the hospital show assets of some $400,000, when the 2,800 family subscribers have paid in only about $140,000? The answer: Most of the excess comes from service given to non-members. Since the physicians who give this service are all on salary, the hospital pockets the fees. It has thus rung up a tidy $350,000 on the extra labors of its staff medical men.

—THEODORE BROOKS

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[1] Personal Communication

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What the Doctor Draft Means to You

Young specialists, ASTP and V-12 graduates seen likely to be first called to duty

• Congressmen wrinkling their brows over draft legislation last month had plenty of company: A good many physicians were asking, "How will it affect me?" Informed observers offered this estimate of how the draft, if it became law, would work:

In the next two years, up to 6,000 private practitioners would be inducted for two-year hitches. Between three and five thousand of this number would be men who had received their medical training at Government expense during World War II. Most of the remainder would be specialists.

May Need More

But the Army added this warning: "Such estimates assume the existence of both a draft and Universal Military Training. Should UMT not be adopted, the armed forces would probably ask for more doctors under the draft."*

The proposed draft law would give the President wide discretion. At his command, every doctor under 45 (including those with families and including physician-veterans) would be required to register. Medical men would be called up according to a priority list. Young doctors trained under the wartime ASTP and V-12 programs who have not served on active duty would be summoned first.

The official priority schedule would probably read something like this:

Doctors in Demand

(1) Doctors trained in ASTP and V-12 programs who had no active military service except during interneship.

(2) Doctors who had no active duty during World War II.

(3) Doctors who served the least number of months during World War II.

Last month the Army and Navy thought there were enough doctors in Category 1 to fill their needs. Over the next two years—if both the draft and UMT went through—the Army (including the Air Force) said it would need to get 5,000 physicians via the draft. The Navy placed its requirements at 1,400.

[*Continued on* 153]

*For separate UMT requirements, see "UMT Would Put Heavy Load on M.D.'s," page 68, May issue.

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Planning Your Retirement Income

Some down-to-earth hints on preparing your exchequer for the day you give up practice

• There's that magazine ad again: "Retire at 55." Sounds like an inviting proposition. Who wouldn't like to relax, travel, and go to bed without worrying about night calls?

But hold it! Before you succumb to the lure of any retirement plan, decide what you're really after.

Are you shooting for simple retirement late in life? Or do you want early retirement and a prolonged vacation? Your choice will make a big difference in the type of retirement program to be adopted.

For example:

If you are 35, a number of life insurance companies will issue you a contract that will cost about $500 a year until you are 65. From that point on, the company will pay you $100 a month for life. This sounds good enough for your minimum needs, but suppose you prefer a large income beginning earlier.

Then consider another policy that will pay $200 a month from age 55. If you start paying premiums at 35, they'll amount to about $1,900 a year.

Should you buy the second contract? Handing over some $1,900 a year in premiums may force you to cut down on vacations while you're still in practice. Do you need vacations most after you retire or during your active years? On that decision rests your choice between a liberal retirement program and a minimum one.

Tapering Off

You may decide that you don't want to retire abruptly. The ties of practice are difficult to break overnight, and you may have some patients you'd like to retain. A slowdown in later years may suit your needs best. This, too, needs some specialized advance planning. For instance:

**Bion H. Francis, author of this article, is an insurance consultant licensed in Massachusetts. He has helped thousands of persons throughout the country with their insurance problems. He is also the author or co-author of such books as "Life Insurance from the Buyer's Point of View" and "How to Start a Life Insurance Program."*

Before you reach the tapering-off point, you'll want to finish paying off certain large expenses. These include all your insurance premiums, the mortgage on your home or office, the educational expenses of your children, and the creation of an emergency fund. Once these big items have been taken care of, you'll be financially able to slow down.

But whether full or partial retirement is your goal, you've got to think about income sources. Consider some of the possibilities:

Assuming 3 per cent interest, a capital investment of $40,000 would be required to produce a $100-a-month income. If you withdrew part of the principal to supplement interest, you might end up by withdrawing too much, thus being stranded without resources before your death. On the other hand, withdrawing too little might mean sacrificing part of the income you could have used.

Such uncertainties can be avoided by using your capital at retirement to purchase an immediate annuity. If this is done, you will make one lump-sum payment to the insurance company. The company will then

"Doctor's office—Gesundheit!"

use principal as well as interest to pay you an income that is mathematically computed to be as large as possible, and yet will continue for your lifetime. The insurance company can spread the risk among large groups of annuitants. It can thus guarantee that the income will continue as long as you live.

Here are the key features of the most important kinds of immediate annuities:

1. A life annuity will pay you an income as long as you live. Because no payments are made to beneficiaries after your death, the income is larger than from any other type of annuity. Buy life annuities only if you wish to obtain maximum income for yourself.

2. A refund annuity will also pay you an income as long as you live. But if you die before the payments equal the purchase price, the difference reverts to your beneficiary. He or she gets either a lump sum (cash refund annuity) or installment payments (installments refund annuity).

3. A variation of the refund an-

TABLE 1

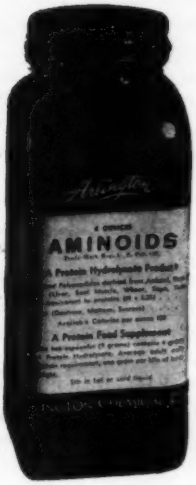
COST OF A $100 MONTHLY ANNUITY

Type of Annuity	Cost When Begun at Age 55	60	65
Life annuity	$21,655	$18,734	$15,907
Installment refund annuity ...	25,867	23,435	21,036
Cash refund annuity	26,782	24,500	22,272
Joint life and survivorship annuity*	29,328	26,257	23,119

* Wife assumed to be two years younger than husband.

HIGH *in nutritional value*

two* HIGHS *in one bottle...



HIGH *in palatability*

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AMINOIDS has high biological value—comparing favorably with that of casein, long accepted as a protein standard.

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nuity is an annuity with payments to your beneficiary guaranteed for some specified period—*e.g.*, ten years. If you die before the end of the guaranteed period, your beneficiary will be paid for the remainder of the period. If you live to the end of the guaranteed period, you'll still continue to draw income as long as you live.

4. A joint life and survivorship annuity purchased for you and your wife will pay an income as long as either of you lives. Such annuities obviously provide better protection for husband and wife after retirement than those mentioned previously.

The cost of annuities has increased frequently during recent years. Current price tags on a $100-a-month annuity, based on standard, non-participating rates, are shown in Table 1.

Tailored to Fit

A joint life and survivorship annuity will often fill a married couple's retirement needs by itself. But sometimes it's well to combine it with a straight life annuity. Suppose, for example, that you and your wife want a retirement income of $200 a month as long as both of you live. But you decide that after one of you dies, $150 a month will

TABLE 2

ANNUAL SAVINGS NEEDED TO BUY A $100 MONTHLY JOINT LIFE AND SURVIVORSHIP ANNUITY

Age When Savings Begin	Annual Savings* to Buy Annuity at Age 55	60	65
25	$ 616	$ 434	$ 307
30	804	552	382
35	1,091	720	486
40	1,577	977	634
45	2,558	1,412	860
50	5,524	2,290	1,243

*Assumptions: (1) annual interest at 3 per cent;
(2) wife two years younger than husband.


tempering the cycle...
In the absence of organic pathology in various aberrations of the menses, Ergoapiol (Smith) with Savin often provides desirable symptomatic relief. For this reason, many physicians prefer Ergoapiol (Smith) with Savin—a preparation containing all the alkaloids of ergot (prepared by hydro-alcoholic extraction), plus oil of savin and apiol. Besides inducing pelvic hyperemia, Ergoapiol (Smith) with Savin exerts a sustained tonic action on uterine musculature, as well as a hemostatic effect.
INDICATIONS: Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and to aid involution of the postpartum uterus.
GENERAL DOSAGE: One to two capsules, three to four times daily—as indications warrant.
HOW SUPPLIED: In ethical packages of 20 capsules each, on a physician's prescription only.
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ERGOAPIOL (SMITH) WITH SAVIN

be sufficient. The following combination of annuity settlements may then be in order:

Type of Annuity	*Monthly Benefit*
Joint life and survivorship	$100
Life annuity for your wife	50
Life annuity for you	50
Total	$200

As long as both you and your wife are alive, this combination will pay $200 a month. After the death of either, one of the life annuities will terminate. This will leave the survivor an income of $150 a month for life.

Suppose you are not yet of retirement age. You can, of course, begin paying for a retirement contract now that will mature later. But a sound alternative is to accumulate the necessary funds by direct investment in securities, savings accounts, and the like. These funds may later be used for the lump-sum purchase of an immediate annuity.

The advantage of this plan is its flexibility. The amount saved each year may be varied according to your income and expenditures. As the fund grows, the interest it earns may be added to it. The annual savings (at 3 per cent interest) required to buy the joint life and survivorship annuity already mentioned are shown in Table 2.

Here, then, are the basic steps to take in planning a retirement program:

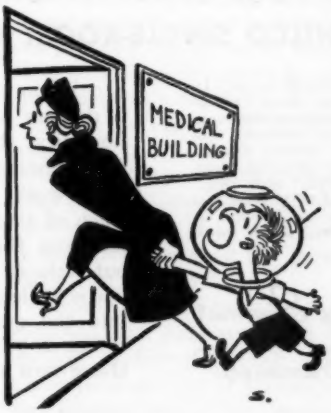
1. Select the proper retirement age. (You probably want to retire as early as possible; but consider how the age at retirement affects the cost of the program.)

2. Plan your expenditures so that payments on mortgages, insurance, educational expenses, and similar items will no longer be necessary after you retire.

3. Choose a sensible retirement income. (Naturally, you want this income to be as large as possible. But think whether greater benefits may not stem from putting some of your money into longer annual vacations while you're young.

4. Develop an annuity program made up of life annuities, joint life and survivorship annuities, or both. (If desired, a slice of capital can also be retained in securities and the interest included in your retirement program.)

—BION H. FRANCIS



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PHILCO SINGLE-ROOM AIR-CONDITIONERS

What the Prepay Plans Are Doing About Transfer Patients

Physicians help take up slack as medical care plans battle administrative snarls

• The doctor reaches for the phone. His secretary could make this call, but the situation intrigues him. He tells his prepay plan director about it.

"A patient of mine has a card showing she's enrolled in an out-of-state prepay plan. She recently moved to this state. Where do we go from here?"

"Tell her to check in with us," says the plan director. "We'll get her transferred to this plan. It'll take about two weeks."

"As long as that?" asks the doctor. "How about that traveling salesman from out-of-state I had recently? I took out his appendix right away. You told me to bill him direct and he could collect from his home plan."

"That case was different, Doctor. Both are what we call reciprocity problems. But the salesman needed care while only temporarily out of his home plan's area. This is a permanent transfer."

"You people have the machinery for this pretty well oiled, haven't you?"

"No indeed! With more than fifty medical plans growing up independently, each has a different contract, a different fee schedule, and various individual twists. Reciprocity is still our biggest internal problem, but we're experimenting with a number of solutions."

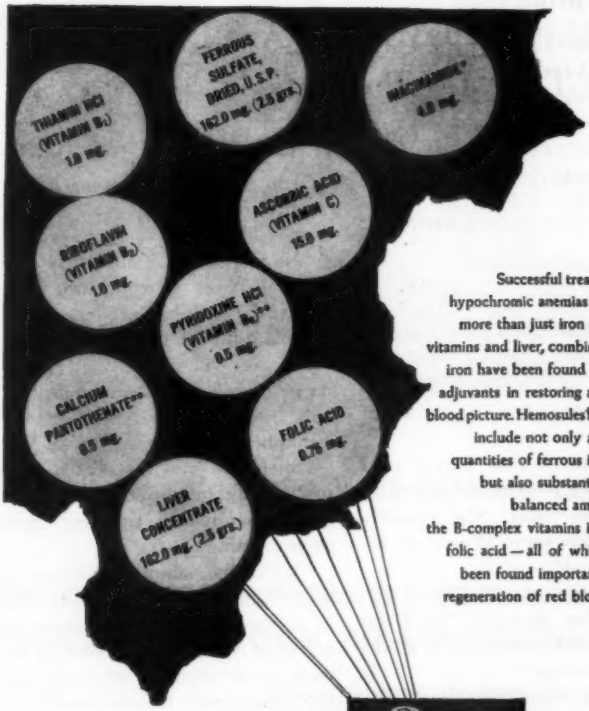
"Such as?" says the doctor. He's particularly interested because he gets a number of transient cases each month.

"Well, the simplest solution is this: One of our subscribers treated in another state makes a claim on our plan. We reimburse him on the basis of our own fee schedule, and the patient pays the doctor direct."

"As in the case of my traveling salesman?"

"Exactly. But that indemnity payment is undesirable, we think. The indemnity system is the most widely used now, but we'd like to get away from it.

"Another way to take care of cases like your salesman would be through an inter-plan bank. Blue Cross has done a lot of figuring on this scheme, but so far, medical



Successful treatment in hypochromic anemias calls for more than just iron salts: the vitamins and liver, combined with iron have been found effective adjuvants in restoring a normal blood picture. Hemosules† Warner include not only adequate quantities of ferrous iron salts but also substantial, well-balanced amounts of the B-complex vitamins including folic acid — all of which have been found important in the regeneration of red blood cells.

"WARNER"

Hemosules†

which are reasonably priced, will prove of benefit for patients who are "run down" or underweight and also for those who require a "pick up" during convalescence from infectious diseases.

*The minimum daily requirement for nicotinamide has not been established.

**The need for pyridoxine hydrochloride, calcium pantothenate and folic acid in human nutrition has not been established.

†Trademark

Packaging: *Hemosules*† *"Warner" —hematinic capsules—are available in bottles of 96 and 250.*

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New York St. Louis

* HANDITIP *

Warming Pad

Many a mother is reluctant to take her infant's clothes off and expose him to a cold examining table sheet. I've found it a good idea to pre-warm the table covering by placing a small electric heating pad beneath the table-top matting.

—M.D., NEW YORK

* * * * *

plans have done little with it. Here's how the bank would work:

"Each prepay plan that belonged to the bank would make a deposit. Then suppose one of your patients received treatment in Florida. The Florida prepay plan would handle the case just as though your patient were insured in that plan.

"Then the Florida plan would bill the bank for the amount it had paid out. The bank would reimburse that plan and deduct the amount, plus a small service fee, from our own account."

"Say, that sounds pretty neat. What are the prospects?"

"Well, Associated Medical Care Plans—that's our national association of prepay plans—has a committee looking over the Blue Cross figures. It's possible a set of tests will be run for medical plans, but it will be a long time before we have a bank in operation."

"How about my permanent transfer patient? How does the reciprocity system work for her?"

"On permanent transfers, we're making better headway. A number of medical plans now have a special agreement saying, in effect, that a patient switching from one plan to another will be covered by the latter until the paperwork is brought up to date. That gets around delays in correspondence."

"That term 'reciprocity' means more to me now. What do you think will be the final solution?"

"It's really too early to tell. About the most hopeful sign is the new district organization of Associated Medical Care Plans. We're getting set up now in twelve geographic districts. In each, we'll have committees to study such things as reciprocity. As we find district solutions, we'll try to work them out on a national basis."

The doctor thanks the plan director for his quick briefing and starts to hang up. As he does so, the prepay official adds this final note:

"Remember that there are thousands of prepay-plan reciprocity cases every year, but only a few complaints from patients. That doesn't mean our machinery is all we'd like. It means most doctors treat patients without question, taking a chance that the paperwork problems will be ironed out. In that respect, most physicians are doing a grand public relations job for prepaid medical care."—C. G. BENSON

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V.A. Doctor Hits V.A. Medicine

Red tape, bungling, said to make the going rough for V.A. doctors; the administration's chief medical director replies

• When an old-time V.A. man hears criticism of the organization, he inevitably counters: "If you think it's bad now, you should have seen it in the old days!"

I don't know about the old days. But from all I can see today, the Veterans Administration has more than its share of fumbling and inefficient practice. Despite the rosy picture painted by some top-level administrators, all is not well with the V.A. medical staff.

Our regional office employs fourteen full-time and four part-time physicians. Three are between 30 and 40 years of age, six between 40 and 50, and nine between 50 and 60. From this one concludes that few younger men are interested in the V.A. as a career.

"How about it?" I asked a number of my non-V.A. colleagues. "Why don't you join up? Why not take advantage of the V.A.'s liberal salaries, its sick leaves, its retirement provisions?"

The main reason, I found, was that V.A. medical practices simply weren't well regarded by the average M.D. Within the organization, there is a tendency to brag about "medical care second to none." In my experience, this is a myth.

When a physician turns a patient over to the V.A., he rightly expects the treatment to be on a par with what *he* could have administered. Such is not necessarily the case. I have seen a patient referred to the V.A. by a private specialist, then

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**The author of this article has been for the past year a full-time medical consultant in a V.A. regional office. Before that he was an internist in private practice. In submitting this article, he wrote: "Most previous discussions of V.A. medicine have presented the ideas of top V.A. administrators. I believe that underlings like myself are in a better position for down-to-earth evaluation—and, since public funds are being spent, that constructive criticism is justified." See page 112 for a rejoinder by V.A. Medical Director Paul Magnuson.*

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For the Deodorizing Bandage *eliminates* not only milder odors occasioned by perspiration, but the overpowering stenches attendant on the closed plaster treatment of purulent osteomyelitis and on fouling of casts by urine or feces.

Acts as "Gas Mask"

Odors are eliminated by *adsorption*, through a group of activated carbons. A cast made with the Curity Ostic Plaster Deodorizing Bandage is thus a veritable "gas mask"—and a blessing to surgeon, nurse, patient and his fellow ward occupants.

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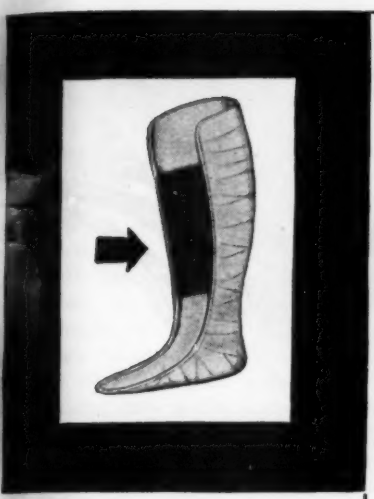

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deodorizing cast. Deodorizing Bandage (arrow) is placed over wound or drainage site. Cast is completed with Curity Ostic Plaster Bandages—they wet out, set and dry in uniform time, make strong, dependable casts with fewer bandages. For satisfactory performance, speed and economy, rely on the Curity Ostic Plaster Line—Bandages, Splints, Deodorizing Bandages!

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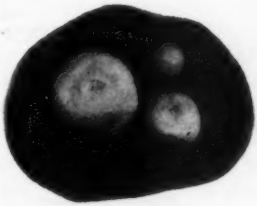

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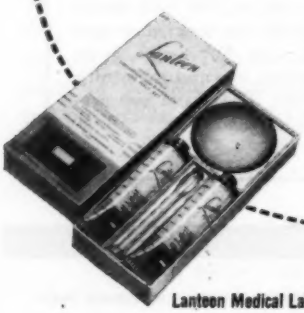

Lanteen

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treated for an unusual heart condition by a V.A. man who had practiced pill-rolling for thirty years and had never even read a medical journal.

The 8-to-5 schedule that constitutes the V.A. physician's working day is not adjustable to patients' needs. What if the patient with severe asthma has an attack during the night? And what if the patient who starts on digitalis Monday shows toxicity on Saturday or Sunday—when the regional office physician is off duty? Such patients have no alternative but to summon private physicians and pay the bills out of their own pockets.

Another gripe concerns flaws in system and planning. Paperwork, for example, is overwhelming. One of my colleagues recently developed partial paralysis of the right hand; in a single day he had been obliged to sign several hundred papers. This was due to a regulation that disallows the use of a stamp, even on carbon copies.

Another cause for hair-tearing is the unevenness of work scheduling. A physician in our office may be told one day to do twenty-five examinations, the next day only three or four. Yet the volume could be easily controlled.

Many treatments given are for non-service connected disabilities. In checking our files, I found that twenty treatment visits were recorded on a typical day. Fifteen of the visitors were employes of the regional office. A further check showed that this ratio held fairly true from day to day. That meant private physicians were losing a sizable number of fees from people well able to pay for treatment.

Waste of the taxpayer's money is, of course, part and parcel of V.A. inefficiency. We have a certified specialist who sees two or three cases a week. Since his salary is about $200 per week, this adds up to nearly $100 per examination. Apparently, no one thought to determine the need for such a specialist before he was hired.

'V.A. Complex'

It is common practice to call in local specialists as consultants, whether the need exists or not. Thus a visiting orthopedic consultant may see two run-of-the-mine cases while the specialist on the full-time payroll sits and twiddles his thumbs.

After serving a while in the organization, even the most stout-hearted M.D. is likely to develop the "V.A. complex." He becomes uncomfortably aware that he is only a tiny cog in a large, inefficient machine. Each of his actions is done according to regulations from the branch office. There is no room for ingenuity or originality. The man who has been rebuffed a couple of times when suggesting an improvement eventually stops trying to better things.

All this is particularly apparent

in the rating of veterans' disabilities. The examining physician has little to do with the actual rating. The rating board is highly insulted if anyone attempts to form an opinion on the percentage of disability. If the examining physician is so indiscreet as to make a diagnosis of "asthma, bronchial, severe (40-60 per cent)," one rating board I know automatically registers the disability as "asthma, bronchial, mild (10 per cent)."

Here are my suggestions for improving the Veterans Administration medical program. They are not the opinions of an "expert." They are just plain horse sense:

¶ Increase salaries to raise the caliber of the V.A. physician. In particular the salary ceiling for rating board physicians should be upped to attract better men.

¶ Plan the regional office's medical care program according to its capacity. Allow the individual doctor a decent day's volume—neither too heavy nor too light.

¶ Listen to the individual doctor's suggestions for improvements. He may have some good ones.

¶ Cut the outmoded, expensive, time-wasting procedures that do not contribute to diagnosis, treatment, or disability rating.

¶ Completely utilize full-time personnel before hiring local consultants.

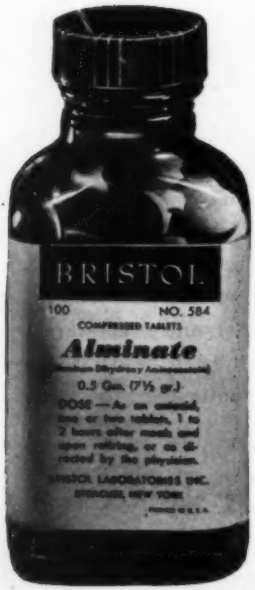
¶ Stop treating V.A. employes for chronic illness.

These improvements, in my opinion, would help restore staff morale to a point where the average V.A.

When you prescribe

Almínate

for IMMEDIATE and PROLONGED antacid action



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Alminate tablets disintegrate rapidly in the stomach and need not be chewed. Although Alminate is designed primarily for ulcer therapy, it is effective also in simple gastric hyperacidity. Continued use does not produce side-effects.

Alminate is available for your prescription in tablets of 0.5 Gm. (gr. 7½) in bottles of 100 and 500 tablets.

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Each Barbonate tablet contains:

Aluminum dihydroxy aminoacetate (Alminate Bristol)	0.5 Gm. (gr. 7½)
Phenobarbital U. S. P. (Warning: May be habit forming)	8.0 Mg. (gr. 1/8)
Belladonna Alkaloids	0.16 Mg. (gr. 1/400)
Oil Peppermint	q/s

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Dr. _____

_____

physician would cease to be a walking advertisement against the organization. —ANONYMOUS

V.A. Response

[*Dr. Paul B. Magnuson, chief medical director of the V.A., was invited to comment on the foregoing article. His statement follows.*]

This article contains many just criticisms. I do not wish to put up an alibi, but I do wish to make known extenuating circumstances that have existed up to the present time.

The Veterans Administration was thrown into the same position that the armed forces were after Pearl Harbor. We were preparing for a war at the same time we had to fight it. We had only about 1,000 doctors in the Veterans Administration medical department when this load of several million veterans was thrown on us. Demobilization was rapid and many men were discharged from the armed forces with disabilities that did not necessitate their confinement in a hospital. In the Veterans Administration program, all the early emphasis was put on the hospital program. Because of this concentration of effort, there has been no time up until now to get our out-patient departments set up and running properly. Thus we have had to accept loads that we were completely incapable of handling.

Even now, the regional offices, where the out-patient departments exist, have inadequate space for our medical activities. I have just re-

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turned from a trip during which I visited a number of such offices. At one place, I found the doctors trying to work in a room that had trucks and trains on two sides and stenographic pools on the other two sides. There wasn't another place in town where you could hang your hat, as far as doing any business was concerned. Even so, the doctors were putting up with the situation and trying to do a good job.

This shortage of space presented an additional handicap in view of the tremendous number of records that had to be kept on hand. It is almost impossible today to locate veterans' records, both because of the lack of proper facilities for storage and because of the difficulties encountered in obtaining records from the armed forces.

On top of this, we took on an enormous number of new people who knew no more about their jobs than I did in 1917, when I went to work in the Surgeon General's Office with the best intentions in the world—and probably the clumsiest methods. We cried for help and, in the field of hospital operations, received assistance from well organized institutions like the medical schools. In the regional offices, however, we had to employ people who had little or no experience either with general administration or with the intricate laws on veterans benefits. All these factors have led to wonderful and magnificent confusion, which we are doing our utmost to straighten out.

Your correspondent makes sev-

eral points that cannot be ignored. The allegation that out-patient treatment is being given non-service-connected cases means, of course, that someone is violating the law, as well as Veterans Administration regulations. It will be a distinct service to me if names can be given where this practice exists.

As for treatment of Veterans Administration employes for chronic illness, if they are veterans and entitled to benefits under the law, we have no other course but to treat them. Again, here is a case where no solution is possible without facts.

Given the name of the doctor who wrote this article, I would be glad to re-employ him and put him to work to correct these faults. There is no doubt in my mind that he has put his finger truthfully on a great many of our difficulties. I am looking for personnel to rectify the situation. I make the offer not to this doctor alone but to a lot of doctors to help us pull ourselves out of the hole we are now in.

[EDITORS' NOTE: *The foregoing letter, we believe, typifies the finest spirit in governmental administration. Medicine can be proud to have as chief medical director of the V.A. a man who is not afraid to admit the faults of his department even though many of those faults were inherited from the past and are not of his own creation. If anything can put the V.A. medical program firmly on its feet, it's the frank, open-minded attitude of physicians like Paul Magnuson.*]

British Doctors Relax Opposition To National Health Act

Modifications planned for national health service are to go into effect July 5

● British Health Minister Aneurin Bevan had given way a little. He had hoped his new concessions would swing a majority of doctors into grudging acceptance of the national health service due to start July 5. At the very least, he had hoped to bring down the opposing majority to a point where they would consider a refusal of service too risky.

Bevan had by no means conceded all the doctors' demands. But on two points he had been accommodating and on certain others he had given assurances that words did not mean what they might seem to mean. (He still returned a blunt "No" to the demand that doctors under the act be allowed to buy and sell their practices.)

For the second time this year, therefore, the British Medical Association decided to poll its 56,000 members. This time, less than half (25,842) voted their disapproval of the modified health service; 14,620 approved; and some 15,000 did not reply.

As the following table shows, the BMA was thus faced with a growing acceptance of the new health service plan. Here's the distribution of votes in the two 1948 polls:

	Feb. Poll	*Apr. Poll*
Approving	9%	28%
Disapproving	73	49
Not Voting	18	23
Total	100%	100%

The BMA now felt that the dissenters were not numerous enough to justify a refusal to serve under the health act. The association therefore announced it was "prepared to advise the profession to cooperate in the new health service on the understanding that the [Health] Minister will continue negotiations on outstanding matters."

Ever since the earlier ballot, when British physicians had registered their opinion that the new act put their freedom in jeopardy, the

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**Harry Cooper, author of this report from England is* MEDICAL ECONOMICS' *London correspondent.*

BMA and Bevan had glared at each other from opposite sides of the fence. Neither had put a foot forward. There had been suggestions that Prime Minister Attlee intervene or that old Lord Addison (who was the first Minister of Health thirty years ago) act as arbitrator; but they had come to nothing.

Elsewhere in the medical profession, though, things had moved. The Royal College of Physicians, whose head is Winston Churchill's doctor, Lord Moran, had passed a resolution suggesting an amending bill to put certain points beyond doubt. But the college (like its sister, the Royal College of Surgeons) is suspect to the general body of doctors as far as medico-political activities are concerned. Neither college is a democratic organization. Doctors get their diplomas and licenses from these institutions but the colleges are not representative of rank-and-file medical opinion. Both of them are ruled by high-up consultants.

A year or so previously, the presidents of the royal colleges had intervened with a letter that had postponed the fight for twelve months.

[*Continued on* 122]

Anecdotes

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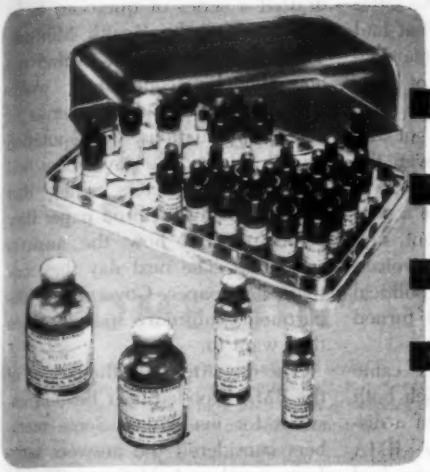

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But, as things turned out, the letter had done no other good. That had not been forgotten, and some doctors had continued to talk of quislings in high places.

But the new resolution of the royal college had given Bevan the opportunity for which he may have been waiting. He had made a conciliatory speech in Parliament, saying no more about "raucous voiced politicians" or "squalid political conspiracies." His gall had turned to honey.

Thereafter developments came quickly. The deadlock, which both sides felt to be something of a disgrace, was broken. The BMA (whose chairman, Guy Dain, had always declared himself ready to consider any reasonable approach) drafted a series of questions to be submitted to the Health Minister. The BMA thus sought to find out how far his conciliatory words could be translated into terms of acts or regulations. A deputation saw Bevan and he gave them oral answers. The doctors replied that without seeing them on paper they could not tell how the answers added up. The next day they saw them on paper—Government departments can move speedily when they want to.

The day after that, the council of the BMA brooded over Bevan's answers for five hours. Some members considered the answers satisfactory; others held that nothing of importance had been gained. Some thought the answers sufficient to

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[1] Malyoth, G.: Klin. Wchnschr. *13*:51, 1934.
[2] Bittner, J. E., Jr.: Northwest Med. *35*:445 (Dec.) 1936.
[3] Myers, P. B., and Rouse, A. H.: Am. J. Digest. Dis. *7*:39 (Jan.) 1940.
[4] Powers, J. L.: Bull. National Formulary Committee *9*:5 (Oct.) 1940.
[5] Block, L. H., Tarnowski, A., and Green, B. L.: Am. J. Digest. Dis. *6*:96 (Apr.) 1939.
[6] Morrison, L. M.: Am. J. Digest. Dis. *13*:196 (June) 1946.

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cancel the mandate given by the recent BMA ballot; others opined that the mandate held with as much force as ever. Guy Dain himself declared that the new Bevan proposals did not go far enough. In any case, it was evident that Bevan had made a clever move. He knows how to divide his opponents.

The BMA council was resolved on one thing: that the decision should rest with the profession's rank and file. Though only a month or two earlier the profession had voted overwhelmingly against accepting service under the act, it would have to vote again. The machinery whereby 56,000 doctors register their opinions was tuned up once more. The question this time was (1) whether they approved the act with the modifications Bevan had proposed and (2) whether they were prepared to accept service under it.

Exactly what had Bevan conceded? The profession had always feared that once the act was in operation the Health Minister could, without reference to Parliament, turn it overnight into a full-time salaried service. This the doctors

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Ascorbic Acid	50.0 milligrams

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would not have at any price, not even at a basic salary of $1,200 a year plus capitation fees. Bevan had said repeatedly that he had no intention of doing any such thing (although to have the doctors in the civil service is one of the professed aims of his party). But what was the value of a politician's word? And even if Bevan could be trusted, what about the next Minister of Health and the one after that?

What the Minister now said was, in effect: "It is rather ridiculous of you to complain of Government by regulations instead of by act of Parliament. Suppose it became necessary to increase the remuneration of physicians. It could be done within a month by regulation; but if it were necessary to get an act of Parliament through, it would take a year." A neat point!

Bevan went on: "If you won't take my word, I will bring in an amending bill stating specifically that this change to a whole-time salaried service cannot be done by regulation, but only by a new act of Parliament." A new act of Parliament would, of course, mean first and second readings, committee stages, and third readings in both houses. Besides, the present Parliament has little more than two years to run. A general election in July 1950 at the latest may bring in a different sort of government.

Bevan went even further than this. The original proposal had been that remuneration in the new national health service be partly by

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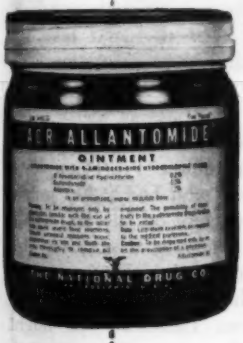

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[1] Martin, G. J. & Moss, J.: Proc. 111th Meeting A. S. C., p. 28. Atlantic City, N. J. (April 14-18) 1947.

[2] Spotts, S. D.: Am. J. Surg. 2:183 (Aug.) 1947.

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capitation fee, partly by basic salary. The basic salary had been regarded with disfavor by the profession as the first step toward a state service. Bevan's professed object in introducing it had been to help the young doctor, who would thus be able to start practice with an assured livelihood. It would also be a means of getting doctors into under-doctored areas. Bevan had believed that an amalgam of salary and capitation would be welcomed by doctors, and in that respect he might have been more right than was assumed. But the leaders of the profession saw the catch in the proposal. Any salary element, in their view, made the doctor the servant of the state instead of the servant of the patient.

So the universal basic salary was abandoned. Instead, a basic salary would be paid automatically to a doctor during his first three years in the service. It would be optional for all other practitioners to take it or leave it; if they did take the basic salary, their capitation payments would be reduced by one-seventh.

This plan was seen to contain certain anomalies. For example, a practitioner who had 2,300 public patients or less on his list would profit by choosing basic salary instead of capitation alone; a practitioner who had more than 2,300 would lose. Therefore one might have in the same town a practitioner who had 4,000 public patients and no private practice and another who had 2,300 and who

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*Am. J. M. Sc. 210:141, 1945

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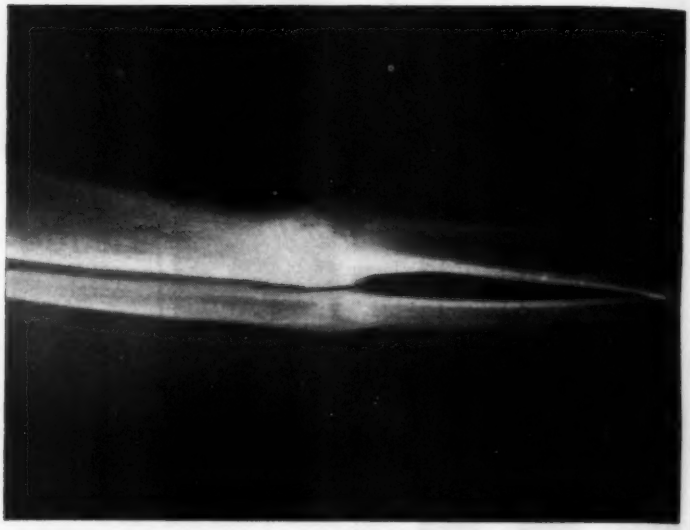

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also conducted private practice on the side. The two doctors would be paid at different rates for their national health service work, the man with only 2,300 having the advantage.

Again, Bevan appeared to have taken it for granted that all young doctors would start practice either by putting up their plates in a new area or by buying established practices. But many young practitioners start in other ways—as an assistant in an established practice, for example. Such men would seem to gain unfairly by choosing a basic salary at the cost of the general pool. When inconsistencies of this sort were pointed out, the Health Minister expressed willingness to discuss them with the profession at an early date.

While all this give-and-take goes on, the poor old British public, which foots the bill, wonders what sort of service (if any) it is going to get on July 5. Both the doctors and the Government are squaring off for final negotiations. Both sides have plenty of ammunition.

—HARRY COOPER

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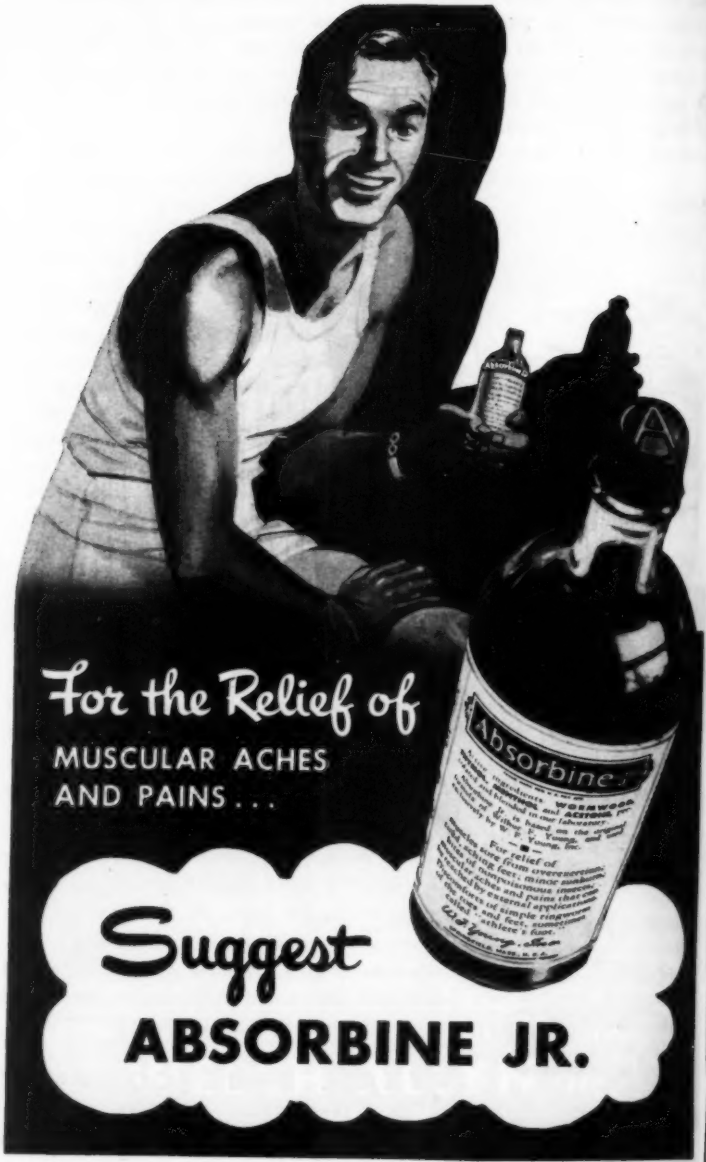
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Costs are up, but not since 1940 have you had a wider choice of where and how to go

• The advance guard of M.D.-vacationers has already descended on the Maine woods, the California beaches, and many another holiday spot between and beyond. Early birds are finding 1948 a far cry from the mad vacation scrambles of recent years. Prices are higher than before; but for comfort and convenience, this summer has it all over the last seven.

Auto travel, for example, is just about back on a prewar basis. Though highways are crowded, they are in far better repair than they were last summer. Breakdowns don't pose much of a threat, since spare parts and new tires are back in abundance. Gasoline costs more, but at least it can be had. Only in the Wheat Belt, where harvesting equipment uses much of the available supply, is there any real competition around the gas station pump.

Thanks to a bumper crop of new roadside cabins and motor courts, you won't have to worry about lodging for the night. Even the older tourist homes and hotels have, for the most part, tidied themselves out of their postwar drabness to compete with the newer hostelries.

It's no longer a seller's market in the tourist business, either. For the first time in years, you can be reasonably sure of service with a smile at most any stopover point. Reservations are still essential at the larger hotels, especially in resort or convention cities; but there's still time to make them.

Train travelers are finding reservations easier to get and the trains themselves more comfortable. New sleeping car equipment has been delayed, but many lines are putting on ultra-modern coaches at a rapid rate. Prices for train travel are up to about 2.2 cents a mile in coaches, 3 cents a mile in parlor cars. Late vacationers may find the rates even higher: The railroads are expected to be successful in their current drive for steeper fares.

Air tourists are making the discovery that added flights and larger planes are helping them to get farther faster—at rates that approximate those for parlor car travel. There's no reservations bottleneck at most airports these days. The same applies to bus terminals, where new land cruisers (complete

with snack bars and air conditioning) stand ready to haul you to holiday spots at minimum cost. The Chicago-New York bus fare, for example, is about $15.

Cruise ships are dotting the Great Lakes, the Mississippi, and the St. Lawrence in greater profusion than in any recent year. Ocean voyages are not back to normal yet, but South American and Caribbean cruises aren't hard to arrange. Typical rates for a seventeen-day cruise (New York-Trinidad-Martinique) are $450-$695.

European vacation centers are making a strong bid for American dollars. England, Switzerland, France, and the Scandinavian countries are already getting tourists in droves. Latin America remains an easier place for travel than Europe, but prices are no improvement on the North American variety. Hawaii has reestablished itself as a topflight vacation setting, though confirmed reservations are a must. Of all the leading holiday spots outside the U.S., Canada is almost alone in offering prices lower than those back home.

"See America First" continues to be the theme of the average vacationer; current reports indicate that most U.S. physicians are following that cue. The time-tested favorites continue to rank high: the Grand Canyon, Yellowstone National Park, the New England mountain resorts, the Arizona ranches, and the shore resorts on both coasts.

—RONALD C. LAIN

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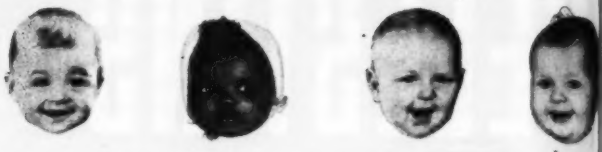

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Ammunition Makers for Social Medicine

Union halls and university classrooms echo the ideas of the Committee on Research in Medical Economics

• Like many other successful partnerships, the chief one working for nationalized medicine combines a fire-eating front-man and an unobtrusive fact-gatherer. Fast-talking half of this team is the Committee for the Nation's Health.* Its background partner is the Committee on Research in Medical Economics.

The two go together as snugly as a new-cut stencil on a mimeograph drum. Which is scarcely surprising; for the CRME provides much of the material that keeps CNH duplicating equipment whirring at top speed. What comes out of this joint effort is highly effective propaganda for a Wagner-type health program.

Like its two-year-old partner, the Committee on Research in Medical Economics was an inspiration of Michael M. Davis. Mr. Davis still keeps a watchful eye on the duo to see that their efforts mesh smoothly.

While the CNH does the shooting, the CRME provides the ammunition. It reads scores of periodicals and reports relating to health questions. It draws conclusions and makes recommendations.

Results of this effort go to the CNH for general release. They also go to people who write to the CRME for information on U.S. health and medical care.

The committee's one full-time researcher and two secretaries handle a fairly steady flow of inquiries. Labor unions, farm organizations, social work schools, and professors of sociology and economics load the CRME mail basket with 1,000-1,500 information requests a year.

In reply, most get copies of printed matter already on hand. Occasional questions, however, require substantial research. If the request comes from someone who commands a large enough following, the committee will go to considerable trouble to supply an answer.

The committee's total expenses run a shade over $20,000 a year. Chairman Davis draws $100 a month (CNH pays him nothing); the remainder goes for office expenses, salaries, and fees to free-lance researchers and writers. Last year, funds came largely from The Rosenwald Family Association and

*See "Committee for the Nation's Health Lays Wagner Bill Groundwork," April issue.

The Mary and Albert Lasker Foundation.

When the CRME was born in 1937, none of its ten members were medical men. Today, of thirteen members, only three are physicians: Channing Frothingham, best-known as the CNH chairman; Claude W. Munger, past president of the American Hospital Association; and Samuel Bradbury, a Philadelphia internist. Among laymen on the CRME roster are Mr. Davis; Morris Llewellyn Cooke, consultant in management problems; Walton H. Hamilton, law partner of former Assistant Attorney General Thurman Arnold; and Harry A. Millis, ex-chairman of the National Labor Relations Board. These men meet about twice a year, usually at Michael Davis' call, to review the work of their hired hands. They seldom have cause to complain.

In its first four years, the committee was connected with some twenty-five studies of medical care problems, many of them critical of organized medicine. In 1941, the CRME began publishing a quarterly magazine called Medical Care. Under an editorial board that included Drs. Ernst P. Boas, John P. Peters, and the late Kingsley Roberts, the magazine plumped continuously for a Wagner health act. War-caused shortages ended this activity in 1944.

In its last issue, the magazine published a review of the CRME-framed "Principles of a Nation-Wide Health Program." In essence,

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these outlined a tax-financed system of medical care for everyone. Actually, publication added little to their prestige. They had already become well-known as a result of a Health Program Conference held by the CRME in 1943.

The meeting turned out to be the noisiest episode in the committee's history. It launched many of the cliches now familiar in the patter of Wagner bill backers. It also brought loud criticism from M.D.'s.

Looking over the list of twenty-nine participants, one doctor charged: "Not more than three of the thirteen physicians in the group are engaged in private practice."

Said another: "On one hand, doctors are accused of opposing a Government plan because it would reduce their incomes. Then we hear that 'a vast majority' of doctors are presumed to favor such a plan because it would increase their income and their security."

After the furor subsided, the CRME seemed to slip into happy retirement. It was, of course, merely switching over to its present role as researcher for the CNH and provider of pro-Wagner bill arguments for all who ask for them.

As for the future, there seems little reason to expect the committee to change its line of activity. As long as grist is needed for the CNH mill, the CRME can be counted on to supply it. And with medical care problems looking more and more like political issues, it's likely that people will continue to write in for "the facts." —HENRY O. PETER

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Assembly [*Continued from* 54]

encouraged by every means.

2. "The people have the right to establish voluntary insurance plans on a cooperative basis. Legal restrictions upon such right—other than those necessary to assure proper standards and qualifications—should be removed.

3. "The medical care section strongly urges joint conferences among representatives of the AMA and of consumers to study the question of the establishment and administration of medical care plans."

No agreement was reached on the issue of a tax-financed health program for all citizens. No delegate had expected it. But both sides of the case got a thorough airing.

At the end of the medical care section's last day, Chairman Leavell shrewdly asked: "Is there any delegate who feels he has not had an opportunity to be heard?" Delegates, squirming from four days of chair-riding, stayed mum. All had had their chance.

Actually, the medical care discussions obscured a number of important NHA recommendations. These included a long list of things the delegates wanted the Government to do—and pay for. Some examples:

¶ Extend the Hill-Burton hospital program ("the current $75 million a year is not enough").

¶ Increase Federal aid to medical schools and medical students.

[*Continued on* 150]

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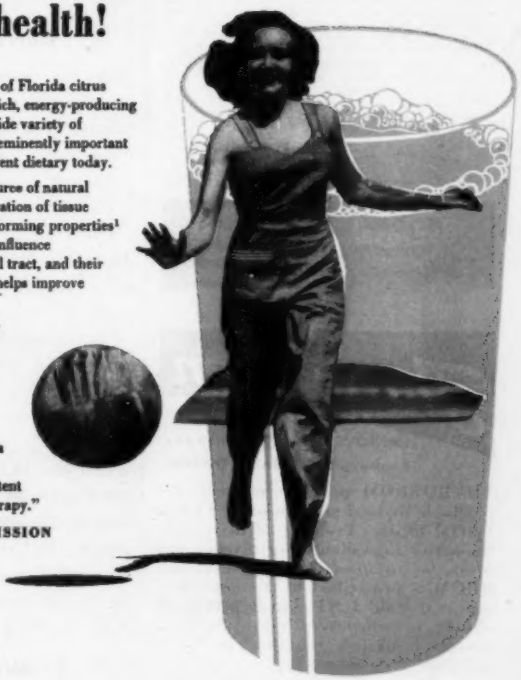
Of great value too, particularly in convalescent diets, is their seldom-failing ability to whet languishing appetites.[1]

For growth, pregnancy, lactation, infant feeding, illness or convalescence, Florida citrus fruits and juices—canned or fresh—constitute potent (and pleasant) "supportive therapy."



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*Citrus fruits are among the richest known sources of vitamin C; they also contain vitamins A, B1, G and P, and other nutritional factors such as iron, calcium, citrates, citric acid and readily assimilable fruit sugars.

References

1. Bridges, R. A.: Dietetics for the Clinician. Lea & Febiger, Philadelphia. 4th ed., 1941
2. McLester, J. S.: Nutrition and Diet in Health and Disease. W. B. Saunders Co., Philadelphia. 6th ed., 1944
3. Sherman, H. C.: Chemistry of Food and Nutrition. The Macmillan Co., New York. 7th ed., 1946

FLORIDA
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¶ Set up under the Federal Security Agency a national nutrition council, a division on chronic disease, and a medical research information center.

¶ Require all hospitals, nursing homes, and other facilities to meet minimum standards and to be licensed by local departments of health.

Garrison Finish

As the assembly neared its end, emotions quieted and tensions eased. It seemed the NHA would close out calmly. A minor flurry centered around the issue of discrimination; but most sections were already on record in favor of complete freedom for racial minorities to receive or to provide medical care.

It remained for the AFL to ring down the curtain with a sharp whack at Dr. Morris Fishbein, editor of the Journal AMA. Before the assembly, said Nelson Cruikshank, when the AFL heard the AMA editor was to speak, it considered passing up the conference on that account. But when assured the doctor would discuss only the innocuous subject of world medicine, the AFL decided to attend.

Controversy Starts

Then, charged the AFL spokesman, Doctor Fishbein pulled a fast one: After delivering his speech on the non-controversial subject agreed to, he issued a supplementary press release dealing with other, controversial issues—particularly health in-

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surance. The AFL, Mr. Cruikshank said, had been double-crossed.

Later in the day, Senator James E. Murray (D., Mont.) tried to get into the act. He took to the radio, borrowed a few arrows from the Cruikshank supply, and singled out Editor Fishbein in a tirade against "political doctors" who sought to block a national health program. But few delegates heard him. Most were scattering homeward with more constructive thoughts in mind.

—EDMUND R. BECKWITH, JR.

Doctor Draft [*Cont'd from* 87]

To start with, the Army figured, it would call on the 2,500 to 4,500 ASTP doctors who had not served on active duty. The Navy estimated that it could count on about 850 V-12 graduates in the same class. After that, the draft would begin pulling other medical men into service.

To physicians, the selective machinery would look familiar. A procurement and assignment service much like that of World War II would probably be set up. It would be a Government agency depending on state and county medical societies for considerable assistance.

But, except to young specialists with no wartime service, P & A would probably not have much significance in the immediate future. ASTP and V-12 graduates would fill the bulk of the services' needs for a good many months to come.

Not until two years hence—barring an international crisis—would other physicians receive draft notices.

—J. D. OBERRENDER

Swingmaster [*Cont'd from* 65]

nized the truth of this, the white-thatched doctor admits; but proof of it never ceases to impress them.

His proudest work hangs under the dome of Topeka's statehouse. It consists of a 207-pound, streamlined bob suspended by 163 feet of piano wire, and is the largest Foucault pendulum in the world. Given an initial push, it swings slowly back and forth for a period of eight hours as the earth turns beneath it.

While it's unlikely that the Davis *chef d'oeuvre* will ever replace the wristwatch, it does also tell time. As the pendulum swings through its steady arc (14 feet every 28 seconds), the hours engraved on the statehouse floor move across the plane of its swing. Spectators find it hard to visualize that they, the floor, and the entire building are moving with the earth, while the pendulum oscillates in its own detached plane.

The retired M.D.'s secondary hobby is travel. Last year his pleasure-driving covered forty-two states. "The universe keeps on the move," says the spry pendulum-swinger. "Why shouldn't I?"

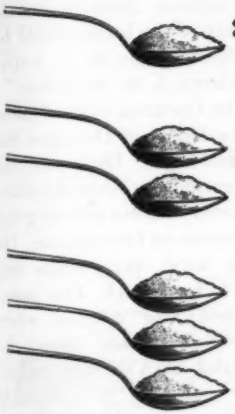
written, the house has usually been "placidly agreeable" to the suggestions of top AMA officers. But recently the delegates have shown themselves less amenable to direction from above. Perhaps the turning point came two years ago at San Francisco: There, when he declined to give the delegates full details on the controversial Rich survey of AMA public relations, the chairman of the Board of Trustees was openly booed.

Soon afterward, the house got its back up over the speaker's habit of using the Board of Trustees as a house reference committee. Utah and Colorado formally protested this procedure, claiming it allowed the trustees to pass judgment on their own actions. The speaker was, by implication, cautioned not to let it happen again.

Secret Sessions

The latest move to democratize the workings of the house is aimed at publicizing reference committee appointments a month before each session. This might subject committeemen to "a deluge of opinions" from the rank and file, the delegates observed. But "any slight inconvenience would be far outweighed by the broad, democratic principles involved."

At least once every meeting, the house goes into executive session. Reserved for discussion behind closed doors are such matters as AMA relations with the National



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stimulates peristalsis and promotes speedy but gentle evacuation

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Physicians Committee and other controversial problems on which the delegates are not ready for publicity.

Not an Exclusive Club

As a precaution against interlopers, sergeants-at-arms usually case the house before each executive session, invite all non-delegates to leave. This practice has earned the displeasure of some state society officers who like to sit in. Says Theodore Wiprud, secretary of the Medical Society of the District of Columbia: "The delegates seem to forget that the house is not an exclusive club. They are first of all representatives of their various state medical organizations. No secrecy should surround their deliberations where [state society members] are concerned.

"It is understandable why the press is excluded from executive sessions. But refusal to admit fellows and members of the AMA . . . is another matter. Those who would justify the house's action say that limiting those present . . . makes it certain there will be no leaks to the press. The fact is that where more than two are present, there is no secrecy anyway.

". . . If the policy-making body of the AMA is as democratic as it claims to be, it would welcome [AMA members] as spectators to all of its sessions. Such an attitude on the part of the house would be a most effective way of . . . inspiring confidence in its leadership."

Like the Congress of the United States, the House of Delegates has its lows and highs. The tempo can drag unbearably, as when delegates spend twenty minutes debating one minor sentence on farm income. On the other hand, proceedings can build up to fever pitch. One memorable peak was reached when Pennsylvania's Elmer Hess denounced the AMA's former public relations counselors so scathingly that the house decided it might be sued for libel if his report were adopted and published (1947). Another dramatic highlight: Lowell Goin's blistering attack on the Public Health Service for its espousal of the Wagner-Murray-Dingell Bill (1946).

Like the U.S. Congress again, the house has members of every hue. It has its fiery orators—*e.g.*, almost anyone in the California delegation. It has its perennial seconders: New York's George Kosmak, Ophthalmology's Bedell. It has its old-world dignitarians: Henry Mundt of Illinois, Leo Christian of Michigan. It has its bright young men, such as 40-year-old James Appel of Pennsylvania, a

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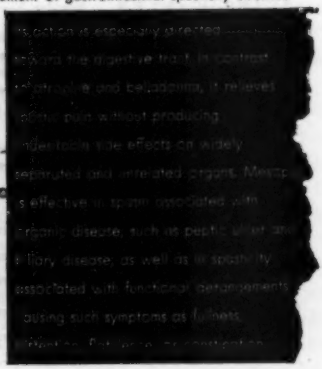

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2	LNR 25G x ⅝" R.B.	Regular Luer	Hypodermic and local anesthesia (raising wheal)
3	LNR 24G x ⅝" R.B.	Regular Luer	Intravenous (syringe) and various veins
4	LNR 22G x 1½" S.B.	Regular Luer	Intravenous (syringe) and fontanel
5	45LNR 22G x 2"	Regular Luer	Anesthesia
6	45LNR 22G x 3"	Regular Luer	Anesthesia
7	LNR 20G x 1½" S.B.	Regular Luer	Intravenous (gravity), intravenous anesthesia, intraperitoneal (saline, Neosalvarsan), Wassermann
(7a) *			
8	LNR 20G x 2"	Regular Luer	Intramuscular
9	LNR 18G x 2" S.B.	Regular Luer	Hydrocele and phlebotclysis aspirating and pneumothorax blood transfusion; intraperitoneal, intramuscular and jugular
10	LNR 19G x 3"	Regular Luer	Hemorrhoidal and hypodermoclysis
11	LNR 15G x 3½"	Regular Luer	Aspirating
12	45LNR 20G x 4"	Regular Luer	Local anesthesia, hemorrhoidal and intracardiac
13	45LNR 20G x 6"	Regular Luer	Local anesthesia
14	462LNR 20G x 3½"	Quincke Spinal with stylette	Sacral and spinal anesthesia
15	462LNR 22G x 2"	Quincke Spinal with stylette	Children's spinal
16	P462LNR 22G x 3"	Pitkin Spinal with stylette	Spinal anesthesia
17	461LNR 19G x 3½"	Spinal with stylette	Spinal diagnostic
18	465LNRC	Regular Curved Tonsil	Tonsil
19	465LNRS	Regular Straight Tonsil	Tonsil
20	480LNR 15G x 2" S.B.	Hose hub needle	Phlebotomy and blood transfusion blood bank donor
21	480LNR 17G x 2" S.B.	Hose hub needle	Blood bank—recipient
22	480LNR 18G x 2" S.B.	Hose hub needle	Blood bank—children

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Consult your supplier for a complete list of needles available from which the above have been selected.

For maximum performance, we suggest the use of Yale B-D Lok-Needles with Yale B-D Lok-Syringes.

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standout committee chairman at the centenary session. And until this year, the house had one of medicine's greatest humorists: the late Holman Taylor, whose Texasisms enlivened AMA sessions for nearly thirty years.

The average physician who sits in on a house session will find much to interest him. He may be bothered by the lack of representation for G.P.'s, for small-town physicians, and for the younger generation. But he's hardly likely to quarrel with the system that made these men the leaders of his profession. For the system is basically a democratic one.

If some of his leaders occasionally seem behind the times, the M.D. from Main Street may well ponder a classic remark let drop at the 1938 session. To the charge made by several medical men that the AMA was a "blundering elephant," Speaker of the House Nathan Van Etten replied thoughtfully: "Remember that *you* are riding the elephant." —ALTON S. COLE

Announcements [*Cont. from* 39]

striking dignity. Gothic type, in light and not-too-dark faces, provides an appropriately quiet tone, but a good printer can show you other type faces that are equally conservative.

The prevailing price for plain printed cards (plus envelopes) is in the neighborhood of $9 for 100, $17 for 500, and $25 for 1,000. If you'd like the more formal, folded type of announcement, add $3 per 100 to that price.

To whom should professional announcements be sent? Primarily, of course, to your present patients. But don't overlook your friends and colleagues. Fellow club-members, local dentists and pharmacists, and physicians with whom you've worked on referrals may be appropriately added to your mailing list.

—NELSON ADAMS

I Killed [*Continued from* 52]

held in pride and not a little awe.

But sooner or later, there comes to every doctor the knowledge that if a situation had been different in some way at some time, a patient under his care might not have died. An added mote of learning, a moment more of leisure, a shade less impatience, and someone might be living. This knowledge is carried silently within him, guarding him from similar pitfalls.

The debatable decision made in the cloisters of medical practice is a burden that must eventually be removed by catharsis. This usually takes place among a group of physicians in the club house, the staff room, or in casual meeting. Sometimes it is initiated by an unfortunate incident in the hospital, sometimes it begins quite spontaneously. Someone starts off with, "Did I

[*Continued on* 162]


Devegan

ever tell you about the patient I killed?" Well, not that he actually killed him, but if . . . Gradually the shock of the phraseology wears off. Soon everyone in the group has added his experience. For a moment the veil is lifted from one of the loneliest aspects of medicine.

The cardiologist tells about his first week of interneship. An old man came in with decompensation and uremia—obviously the end result of arteriosclerotic heart disease. The patient was one of a dozen admissions that day; in addition, the young interne had inherited a ward. His resident made a seemingly casual observation that a rectal examination had been omitted. But in the excitement, the interne failed to perform one. Two days later, when the man was posted, he was shown to have a benign hypertrophy of the prostate, with urinary obstruction. If . . .

The cardiologist reaches into his pocket and pulls out some finger cots. "No alibis, but I've never omitted that examination since then."

The surgeon breaks the silence to tell of a woman with a carcinoma of the hepatic flexure. He entered the abdomen, found no obvious metastases, resected the involved bowel, and did an end-to-end anastomosis. The patient made an uneventful recovery, but eight months later she came back with jaundice, loss of weight, and abdominal pain. She had that "cancer look." He gave her supportive treatment and

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Tyree's Antiseptic Powder offers the busy physician a *balanced* vaginal douche . . .

BALANCED Psychologically . . . by imparting immediately a sense of cool, clean, gratifying comfort, Tyree's restores the woman patient's subjective balance and makes her amenable to further curative treatment.

BALANCED Physiologically . . . by correcting hypo-acidity present in the vaginal pathology with Tyree's, it is possible to approximate the normal vaginal pH of 4.0—a condition very hostile to the growth of vaginal infections.

BALANCED Therapeutically . . . finally, Tyree's value as a vaginal douche is positive, because it balances *effectiveness* with *safety*, avoids complications caused by caustic, irritating douching, while it acts as an effective treatment in vaginal infection. Try Tyree's the next time you prescribe a vaginal douche. Write for literature and professional samples.

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To COUNTERACT MILK ANEMIA

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This product is also an ideal nutritional adjuvant and hematinic tonic for older children and adults of all ages. It is therefore available in two forms: a regular 8 ounce bottle, and a special 2 ounce dropper bottle for infant feeding. The adult dose is 2 teaspoonfuls twice daily. The dose for children under 15 years old is 1 teaspoonful twice daily. The infant dose is 1 to 10 drops daily in milk or water.

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made her last days comfortable with sedation. The post showed only a common duct stone, empyema with rupture of the gall bladder, and a terminating peritonitis—no evidence whatever of a neoplasm.

"I've never given up hope on any patient since then," the surgeon concludes wryly.

"It was a perfect psychosomatic history," starts the internist. A middle-aged widower who had been rejected by his children began to have many attention-getting complaints. His symptoms were bizarre and dramatic. For example, within seconds his stomach would distend to enormous proportions, then as suddenly decompress. Given some sympathy and encouragement, he became almost asymptomatic. But six months later, he had a supraclavicular node. Further study revealed a gastric carcinoma.

"I think my trouble was that I made the diagnosis before I actually examined him."

That reminds another doctor of a patient who was a pest. He came every week with varying complaints. One week he told about his insomnia and nervousness. The next time it was his digestive tract that bothered him. After that, he grumbled about his headaches and tiredness. This continued for six months. Finally, the patient turned up complaining of pain in the chest. He was given a cursory examination and told that he was in fine shape. While dressing, the patient dropped dead.

"Bad publicity aside," the doctor remarks dryly, "I've learned to believe what my patients tell me."

Around the room goes the confessional, from the pediatrician who hurried through instructions to a

Rough Stuff

• Sophie the technician had been sent to do a blood count on Mrs. N in the psychopathic ward. She had been warned that the patient occasionally became violent; but she had no trouble until ready to leave. As she headed for the door, Mrs. N began to follow her. That scared Sophie plenty, but her fright was compounded when she found the door locked. She then began circling the room, with Mrs. N in pursuit. First she walked. Then she broke into a terrified run. She ran until she could run no more. At last Mrs. N caught her. With an insane gleam in her eye, she tapped Sophie on the shoulder and cried, "You're it!"

—M. T., PENNSYLVANIA

new mother to the gynecologist who wouldn't investigate the Mayor's wife for gonorrhea. There is some comfort in the burden shared, some unction where the conscience pricked, some solace in the common woe. Above all is the determination that is half a prayer: "Never again, dear Lord."

—THEODORE KAMHOLTZ, M.D.

Chiropractors [*Cont. from* 43]

thirteen chiropractic schools under the G.I. Bill of Rights) seek to have members of the cult commissioned in the military medical departments.

Just what the potential membership of organized chiropractic is, no one knows. Leaders in the field admit freely that many holders of chiropractic degrees have laid them aside and taken up other occupations. Best estimates of the number of working chiropractors range from 30,000 down to the NCA's figure of 20,000.

The number is going down steadily. B. J. Palmer thinks it has dropped 50 per cent from its peak. He frankly tells his colleagues why: Chiropractors are retiring or dying, state after state is establishing basic science laws; educational requirements have been stiffened so "it is impossible for mother schools to graduate sufficient quantities to fill the thinning ranks."

There is no lack of effort on the part of the schools, though. They vigorously recruit new students with such come-ons as "do you want to be a laborer or a professional man?" Then they heap on statistics about chiropractic incomes. On the whole, the cult collects an estimated $30 million a year. Currently, the NCA says, an individual chiropractor can expect to average $1,500 his first year, hit a peak of about $7,500 between his tenth and fifteenth years. To men who may lack even a high school education, it doesn't sound half bad.

Some student prospects cast a wary eye on the legal hazards of chiropractic. They may have heard that half the chiropractors in certain states are forced to practice without licenses. Or they may have seen newspaper estimates that New Jersey chiropractors, for example, have been fined in the past eight years

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IN PROPHYLAXIS—Meonine is useful in the prevention of liver damage. It tends to prevent fatty infiltration, necrosis and cirrhosis due to alcoholism . . . malnutrition . . . surgery . . . pregnancy . . . infectious diseases . . . industrial poisons (such as carbon tetrachloride, TNT, or commercial plasticizing solvent) . . . and medicinal poisons (such as arsenic, barbiturates, and chloroform).

Meonine, 1-3 tablets twice daily (1-3 grams), supplies the same amount of methionine as 1-3 quarts of milk. Best results are noted when given with a high protein diet enriched with the vitamin B complex.

IN THERAPY—Meonine reverses fatty infiltration of the liver. While it does not replace fibrotic tissue or repair the cell destruction of yellow atrophy, it prevents further insult and helps promote regeneration.

Meonine has been successfully prescribed in cases characterized by low serum protein, jaundice, ascites, hepatic enlargement, or other signs of liver injury.

The average dose of 3-6 tablets twice daily (3-6 grams) is supplemented by a high protein, high carbohydrate diet, with the vitamin B complex and a protein digest.

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an average of $500 each. Still other prospects may wonder why the Chiropractic Institute of New York is currently being tried as an unlicensed trade school.

To such men, the schools are reassuring. They may, for example, explain their legal arrangements. The NCA sells two kinds of legal aid memberships, one for licensed chiropractors, one for unlicensed. Both entitle the member to defense by the NCA legal staff in case of arrest or suit. If the court imposes fines or judgments, they are paid by the association.

Have a Lawyer!

The Palmer school also offers legal assistance through its Chiropractic Health Bureau. This enterprise offers insurance against malpractice judgments, counsel fees, and court costs. Premiums are supposed to be $10 a year, but the bureau's regulations stipulate that members may be taxed when money is needed. This happens frequently, for the bureau pinches no pennies when danger appears. Costs for single cases often range between $1,500 and $5,000. At least once, they topped $10,000.

The prospective student can't fail to be impressed by chiropractic's defense record. One prosecution in five results in a conviction. The reasons for this low rate aren't hard to find:

Getting evidence against chiropractors is, in most states, a laborious process. Complaints must usually be made in writing. Then a medical or other state inspector must investigate. In one state where the cult is illegal, chiropractors are armed with pictures of all investigators. Thus they are quickly aware of any probe into their work.

Then too, complainants are required to testify in person when a case comes to court. Many shy at that. Others lose interest because of delays with red-tape.

Revelation of such trade-secrets to students is apparently not enough to win large numbers of recruits. The trend toward fewer practicing chiropractors is worrying the national leaders. To combat the trend, they're thinking about starting new schools.

Probably 500 to 600 chiropractic colleges have existed in the U.S. at one time or another. A few years ago there were about twenty to forty. Today the NCA counts six "approved" schools, three "conditionally approved," and two "undergoing reorganization." On the docket of a new organization called the Chiropractic Research Foundation is a project to establish fifteen new schools in the next five years. Pre-

sumably, these new schools will meet NCA standards.

As a matter of fact, NCA recognition is largely a quantitative matter. So is approval by the American College of Chiropractors. Schools that advise the ACC their course covers at least 3,500 hours of study are rated "A" without further inquiry.

This quantitative approach reflects the chief split within the chiropractors' ranks. The "straights," those who stick to spinal manipulation, believe that as little as one month is enough to train a chiropractor. The "mixers," those who have adopted many medical techniques (including X-ray and blood analysis), think a four-year course is essential. Today most chiropractic schools offer the long course.

There are other signs that the "mixers" are winning out. Some chiropractic organizations have assumed titles that make them sound like medical units. The National Council on Public Health and Research is one example.

News releases from the NCA often sound medical tones. Not long ago an NCA release told of a symposium that included such subjects as "The Public Health Significance of Cardiac Diseases," "Our Attitude Toward Infectious Diseases," "Poliomyelitis," and "Roentgenology." A good many lay editors and their readers probably assumed the participants were doctors of medicine.

Such publicity indicates more than a trend toward "mixing." It

Clinical tests prove that PRO-CAP is less irritating

"141 patients, including the 130 developing adhesive irritations of various degrees, were then exposed to the adhesive tape containing the fatty acid salts. The plaster was used 970 times on these patients. Only 5 patients developed irritations which were sufficient to cause complaint. The irritation even in those instances was not sufficient to warrant discontinuation of the use of this new plaster."

—*R. E. Humphries. New Factors in Adhesive Formulas Which Lessen Irritation. J. Investigative Derm. 9:219-220 (Nov.) 1947*

SEAMLESS PRO-CAP ADHESIVE PLASTER

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Seamless PRO-CAP is a superior quality Adhesive Plaster containing zinc propionate and zinc caprylate—two medically-proved ingredients. PRO-CAP provides these *three* important advantages, *at no increase in price!*

- **Skin irritation and itching are substantially eliminated.**
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RESULT: More comfort for your patient . . . Less interference with your treatment . . . We invite you to discover PRO-CAP's outstanding qualities in your own practice. Write for illustrated brochure and reprints of medical reports.

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also shows clearly how publicity is used by chiropractors to impress the laity.

The NCA overlooks few bets in getting its message across. A publication called Healthways Magazine and radio transcriptions entitled "Miracles in Health" leave little to the imagination. Testimonials from patients are often included.

Forever Amber

Possibly the most famous of all chiropractic testimonials was actually published in the Chicago Tribune some time ago. It said: "Before taking chiropractic and electric treatments, I was so nervous that nobody could sleep with me. After six treatments, anybody can sleep with me."

Advertising by individual chiropractors is encouraged by the NCA and by the schools. The cult's code on this matter was once crystallized in The Chiropractor, a monthly publication of B. J. Palmer's school: "Advertising to attract attention need not be considered as an evil or stigma so long as the services can equal the claims."

Presumably that tenet is known to most chiropractors, who interpret it liberally. Witness the claim circulated to employes of one New Jersey industrial firm:

"Avoid the knife. Try my chiropractic method to prevent surgical operations for the following ailments: appendicitis, tonsilitis, tumors, stomach ulcers, gallstones, piles. For speedy relief, use chiropractic for all ailments."

Thus do individual chiropractors hawk their own wares while the NCA publicizes the profession. But no one connected with chiropractic has yet approached the promotional genius of its first high priests.

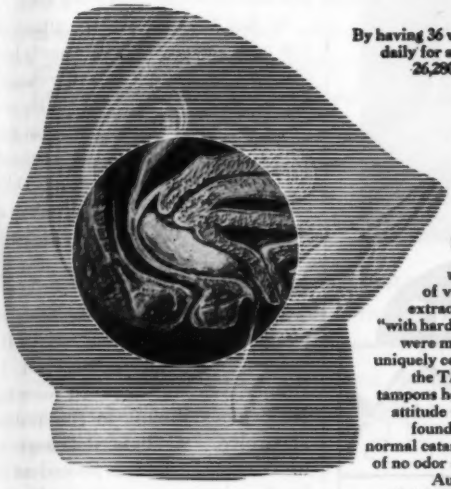
The Old Man

Chiropractic's inventor, Daniel David Palmer, was a country storekeeper, but no ordinary one. He had the beard and the burning eye of a prophet. And he had a prophet's fondness for revelations.

About 1886, D.D. discovered that his body was charged with "animal magnetism." To divorce himself from his cracker-barrel atmosphere, he moved to Davenport, Iowa, and set himself up as a magnetic healer. Magnetic healing af-

for 60 days or 200 Years*

TAMPAX *is safe!*



By having 36 women insert TAMPAX twice daily for a solid year—using a total of 26,280 tampons, or the equivalent of a 200 years' supply for one woman—a leading gynecologist has proved *unequivocally* that TAMPAX *is safe!* Continuing bacteriologic studies, biopsies, pH and glycogen determinations and gross visual and pelvic examinations before, during and after TAMPAX usage revealed no evidences of vaginal irritation during this extraordinarily harsh test. In fact, "with hardly an exception, the findings were most favorable."[1] During this uniquely comprehensive investigation, the TAMPAX wearers reported the tampons helpful in their psychological attitude towards menstruation; and found them no impediment to the normal catamenial flow, and productive of no odor associated with the menses. Authoritative studies by other clinicians[2,3,4,5] have confirmed these findings, and further corroborated the now indisputable fact that TAMPAX cannot cause irritation, erosion or vaginitis. These are but a few among the many cogent reasons why TAMPAX is more than ever, today, the internal menstrual guard of choice!

**Approximate total number of days of menses in year.*

REFERENCES: 1. West. J. Surg. Obst. & Gynec., 51:58, 1943. 2. J.A.M.A., 120:490, 1945. 3. Am. J. Obst. & Gynec., 46:259, 1943. 4. Med. Rec., 155:314, 1942. 5. Clin. Med. & Surg., 46:327, 1939.

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forded ample opportunity for th cultivation of unusual theori about disease. By 1895, these we ripe for testing. The human guine pig was one Harvey Lillard.

Lillard had been deaf for seve teen years, according to D.D.'s so Within ten minutes, however, chir practic had proved itself. Lillard hearing was restored, never to l lost again—so the testimony goes.

At first the new science attracte few adherents. This was partly be cause D. D. Palmer feared someon would steal his discovery. He re fused to treat patients except in th dark. When fellow-healers begge to be let in on the secret, D.D charged them $500 a demonstra tion.

Schoolboy Healer

It was the salability of chiropra tic that struck the son. If D. D Palmer was extraordinary, B. J Palmer was—and is—even more s He began dabbling in chiropracti at twelve. A slight deficiency i his education—he was invited out o his first high school class when h let rats loose in the classroom—wa offset by his father's gift of a D.C (doctor of chiropractic).

But that failed to satisfy B.J He later had the Palmer schoo award him the honorary degree o Ph.C. (philosopher of chiropra tic). At the time, quite incidentally, he owned the school.

In 1903, when D.D. was jailed for practicing medicine without a license, opportunity knocked for B.J. When the father came out

What measures literally smooth the way?

SARAKA—superior colloid laxative—literally smooths the way to normal bowel function without the disadvantages of the oily lubricants, viz. impairment of fat-soluble vitamin absorption and anal leakage. Effortless movements are promoted by a soft, mobile, demulcent mass, counterpart of nature's own gentle stimulus to intestinal propulsion. The urgent, unphysiologic evacuation of profuse watery stools, as with antacid and saline purgatives, is avoided. Optimal hydrophilic activity after leaving the stomach avoids bloating.

Noteworthy among the distinctive features of SARAKA's bland vegetable hydrogel, *bassorin*, is its unrivalled water-imbibing and water-retaining potency. A further advantage is its non-absorbability which maintains undiminished stool volume. Being non-digestible, it passes unaltered through the intestinal canal and releases no irritating end-products.

The eminent advantages of SARAKA are reinforced by its availability in three forms to meet the needs of specific types of therapy:

SARAKA with *frangula* for mild enhancement of intestinal motility.

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a 2 weeks' clinical supply for 2 patients

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of prison he found his son in control of the school. B.J. had not forgotten he had once been "kicked from home." There was no room in the school for old D.D.

When B.J. took over the school, it had about twenty students. By 1921, Medical Examiner Charles B. Pinkham could testify that "the annual output of a single chiropractic school [Palmer's] equals the total output of the combined medical schools of the U.S." Known by then as "The Fountainhead," the Palmer school showered its owner with an estimated gross income of $1 million a year.

This was accomplished despite competition from a host of imitators. Far from discouraging these rivals, Palmer welcomed them. To cut such a cult out of whole cloth, he was aware, would require allies –and the more the better.

This wish for more chiropractors weighs heavily today with the cult's leaders, and for the same reasons. When these men gathered last month for their convention, they undoubtedly summed up their prospects. A clear-eyed appraisal might have run this way:

"New schools and new graduates will still mean little so long as we are dominated by medical practice acts. As we have said before, our real targets are the legislatures. If we avoid stirring up opposition from the doctors, there's a chance we can get what we want."

—MORRIS WEINTROB, M.D.

Just Published

ARTICLES

ARTIFICIAL INSEMINATION. By Clintie Winfrey Kenney. What's what about artificial insemination, explained for laymen. American Mercury, April.

HORROR IN THE NURSERY. By Judith Crist. Quoting extensively from Psychiatrist Frederic Wertham, this article argues that comic books upset the kiddies' morals. Collier's, March 27.

NEW LIGHT ON LEPROSY. By Lois Mattox Miller. Little known facts about leprosy. Reader's Digest, April.

THAT FANTASTIC GLAND, THE THYROID. By Steven M. Spencer. All about new treatments for thyroid disorders. Saturday Evening Post, April 10.

THEY DON'T HAVE TO GO BLIND. By Steven M. Spencer. What can be done to save the sight of glaucoma victims. Saturday Evening Post, March 20.

BOOKLETS

GOOD HEALTH IS GOOD BUSINESS. Prepared by a joint subcommittee on health of the National Planning Association. Recom-

mendations on medical care and other programs in industry and agriculture. 48 pp. National Planning Association, Washington, D.C. 25 cents.

LAW OF ADOPTION SIMPLIFIED. By Morton L. Leavy. Handy reference manual of adoption procedures and regulations in all forty-eight states. 80 pp. Oceana Publications, New York. $1.

PHYSICIANS AND SCHOOLS. Edited by Dean F. Smiley, M.D. and Fred V. Hein, PH.D. Report of the 1947 AMA conference on school health and physical education. 32 pp. American Medical Association, Chicago. Gratis.

BOOKS

I LOVE MY DOCTOR. By Evelyn Barkins. A doctor's wife tells about her first year of marriage. Thomas Y. Crowell, New York. $3.

PSYCHOSOCIAL MEDICINE. By James L. Halliday, M.D. A psychosomatic analysis of what ails modern society. 278 pp. Norton, New York. $3.50.

THE VETERANS ADMINISTRATION RATING BOARD RACKET. By Matthew A. Liotta, M.D. A former medical rating specialist for the VA explains which veterans' claims are valid, which are not—with some sharp raps for the VA system. 104 pp. J. J. Cavanaugh, New York, $2.

The Newsvane

Salaried British M.D. Flirts With Red Ink

Salaries for London physicians, which often run around $3,200 or $4,000, do not provide a living wage for a doctor and his wife, says Surgeon Harold Dodd, writing in The Lancet. He cites the following budget for a typical London couple with no children:

Rents, taxes, garage	$1,000
Food, laundry	1,040
Electricity, fuel	140
Vacation, fares	200
Clothing, furniture	600
Insurance, sickness, etc.	400
Telephone	80
Gifts, entertainment	100
Car	400
Income tax	1,200
Total	$5,160

Doctors Sponsor Own Auto Phone System

A cooperative, nonprofit auto-phone organization, sponsored principally by physicians, is now operating in Freeport, New York. Subscribers who have had two-way radio sets installed in their cars can reach their offices or any other telephone station within 15 miles through a special switchboard run by a local telephone-answering service.

Nurse-Anesthetists Backed by ACS

Stop propagandizing against nurse-anesthetists, who have a "splendid record of achievement," the American College of Surgeons has told anesthesiologists. While it supports the trend toward use of anesthesiologists, says the ACS, there aren't nearly enough to go round. Not only must surgeons go on using nurse-anesthetists, it continues, but they should encourage institutional training of more of them.

Sex in Sect Suffers Slight Setback

Temporarily out-of-bounds for the stork is the Doukhobor settlement at Hilliers, Vancouver Island. Heretofore, any woman in the marriageless colony could select a likely looking male, get a permit from the elders, and settle down to procreation. This arrangement not only proved distracting for the more

virile men but produced more babies than the colony could handle. So, say the elders, no more permits will be issued for a while. Meantime, men will use some of their energy in building additional nurseries and kindergartens.

Journal Supplements Planned for '49

An authoritative review, "Medicine of the Year," is being planned by a group of medical educators for distribution once a year as a supplement to state journals. It will cover general practice and the major specialties. Profits from annual subscriptions (set tentatively at less than $2) and from advertising will be shared by the sponsors with cooperating medical societies. First issue is scheduled for distribution with state journals in January 1949.

Numbered Babies Due Next Year

Newborn American babies will be assigned serial numbers in a national system getting under way the first of next year, the Public Health Service announces. All U.S. numbers will start with 1, all Canadian numbers with 2. Following this numeral will be two indicating the state—*e.g.*, 01 for Alabama, 48 for Wyoming. These are followed by a dash and by two numbers to indicate the year. Finally, in a six-digit set, comes the baby's number. Thus, the first 1949 infant in Alabama will

n a class by itself

Sodium sulfacetimide is the *only* sulfonamide which can be dissolved to the extremely high concentration of 30% *at physiologic pH 7.4.* It is *more bacteriostatic* than any other sulfonamide used locally, more deeply penetrating into ocular tissues, and yet virtually nonirritating.

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For more certain *prevention of infection* following all types of corneal abrasions, lacerations and burns, or after removal of embedded conjunctival and corneal foreign bodies, one drop of SODIUM SULFACETIMIDE SOLUTION 30% should be instilled every two hours for at least one day after injury.

For *rapid control of infections* such as acute and chronic conjunctivitis and blepharitis, and to speed healing in traumatic corneal ulcer, one drop of SODIUM SULFACETIMIDE SOLUTION 30% should be instilled every two hours until improvement is well under way, after which treatment is continued at longer intervals for one or two days more.

For continuous therapy through the night, SODIUM SULFACETIMIDE OPHTHALMIC OINTMENT 10% should be applied to the lower lid at bedtime.

SODIUM SULFACETIMIDE SOLUTION 30% (Sodium SULAMYD®) is available in 15 cc. amber, eye-dropper bottles. SODIUM SULFACETIMIDE OPHTHALMIC OINTMENT 10% (Sodium SULAMYD) in ⅛ oz. tubes. Box of 12 tubes.

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be assigned 101-49-000001; Wyoming's will get 148-49-000001.

Oust Bedwarmers From Veterans' Hospitals

Patients who occupy V.A. hospital beds when their conditions warrant only ambulant treatment will get short shrift, says Dr. Paul Magnuson, the administration's medical director. He announced recently that he was beginning to roust them out. In one housecleaning, V.A. doctors went through a hospital and wrote discharges for 40 per cent of its 1,900 patients.

HANDITIPS

▶ What nontechnical procedure or device have you found helpful in conducting your practice more efficiently? MEDICAL ECONOMICS will pay $5-$10 for original ideas worth passing on to your colleagues. Address Handitip Editor, Medical Economics, Rutherford, N.J.

Says Convicts Display Psychosomatic Needs

Family tension, even of a subtle nature, breeds physical and mental ills and may develop children into criminals, says Dr. David Abrahamsen of Columbia University's psychiatry department. Having made a four-year study of convicts, Doctor Abrahamsen declares that half the prisoners had psychosomatic disorders, including symptoms of

cardiac, neurological, skin, and respiratory diseases. These he links with evidences of anxiety, envy, cruelty, and lack of affection. "In all the families examined," he says, "there was an emotional tension. This was found to be a breeding place for hostility and resentment."

Hospital Staff Forms Diagnostic Group

A new diagnostic clinic for private, paying patients has been formed by forty-four staff members of the Pennsylvania Hospital, Philadelphia. The group rents space and equipment from the hospital, gives complete work-ups on a flat-fee basis. Income is shared according to a weighted formula that recognizes the amount of time and effort given to the group by each doctor.

Judge Asks for It— And Gets It

Alienists who have had to endure the bumbling of judges are applauding the temerity of a Detroit colleague, Dr. Baxter B. Fair. He is the director of the city psychopathic clinic, which furnishes reports in commitments and other legal actions. Two judges, Paul E. Krause and John J. Maher, have been disparaging the reports or ignoring them altogether, Doctor Fair says. He challenges their right or wisdom in doing so. The matter came to a head when Judge Maher tore up a report in court with the remark, "If I went to the clinic myself, I'd probably be found unstable, too."

"I don't think there is any question about that," Doctor Fair retorted. "I think that any man sitting in a judicial capacity who loses his self-control to that extent is unstable."

Prepayment Booming Beyond AMA Hopes

The progress of Blue Shield prepayment plans is exceeding earlier predictions of the AMA Council on Medical Service, the council's latest report shows. Enrollment grew 50 per cent in 1947 and at year's end stood at a total of 7½ million persons.

During 1947, fourteen plans enrolled more than 50,000 new members each. They included United Medical Service, New York, with a net increase of 324,567; Massachusetts Medical Service, 265,000; Ohio Medical Indemnity, 223,256; and California Physicians' Service, 99,119.

Four plans reported a total of membership of more than 500,000

ANECDOTES

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Address: Medical Economics, Inc., Rutherford, N.J.

each at the end of 1947: Michigan Medical Service, 935,531; United Medical Service, New York, 730,293; Massachusetts Medical Service, 725,519; and California Physicians Service, 518,791. Five other plans had more than 200,000 members each and eleven other plans more than 100,000 each.

Percentage of income paid out in benefits averaged 77.9 per cent among all the plans in 1947. Average administrative expense was 13.9 per cent.

Decries Scare Themes For Health Drives

Slogans designed to shock people into contributing to health drives are helping to make us a nation of neurotics, warns Dr. Paul V. Lemkau, director of mental hygiene study at Johns Hopkins. What's more, he says, there is no proof that such slogans are effective. Doctor Lemkau condemns phrases like "One out of eight will die." He says we may wind up with an all-out, all-inclusive drive keynoted by the sepulchral slogan, "Everybody dies."

Would Make Societies Accept Negro M.D.'s

The AMA's constitution should be amended so that no Negro doctor can be barred from county society membership because of his color, the New York County medical society has resolved. It asks that the New York State medical society introduce a similar resolution at the AMA convention. "The exclusion of physicians on the basis of race," says the county society, "constitutes an affront to our colleagues, a

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From the Atlantic to the Pacific, throughout the United States, physicians are prescribing RIASOL for the relief of psoriasis. This clinically tested antipsoriatic has won the confidence of physician and patient alike, because it really *works*.

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degradation of the honored traditions of our profession, and a violation of our American democratic ideals."

Only 28 Physicians in V.A. Teapot Tempest

Only twenty-eight doctors of the 87,000 participating in V.A. home-town plans have been found guilty of transgressions warranting action by the administration, the V.A. has disclosed. Seven cases that involved outright dishonesty—charging for services not given, etc.—have been earmarked for criminal prosecution. The other twenty-one physicians, most of whom were accused of overcharging, have been barred from V.A. practice and have been disciplined by their own medical societies.

Hospital Care in Home Brings Costs Down

The "home care program" for incurables, established by New York's Montefiore Hospital, is bringing inquiries from hospitals in all parts of

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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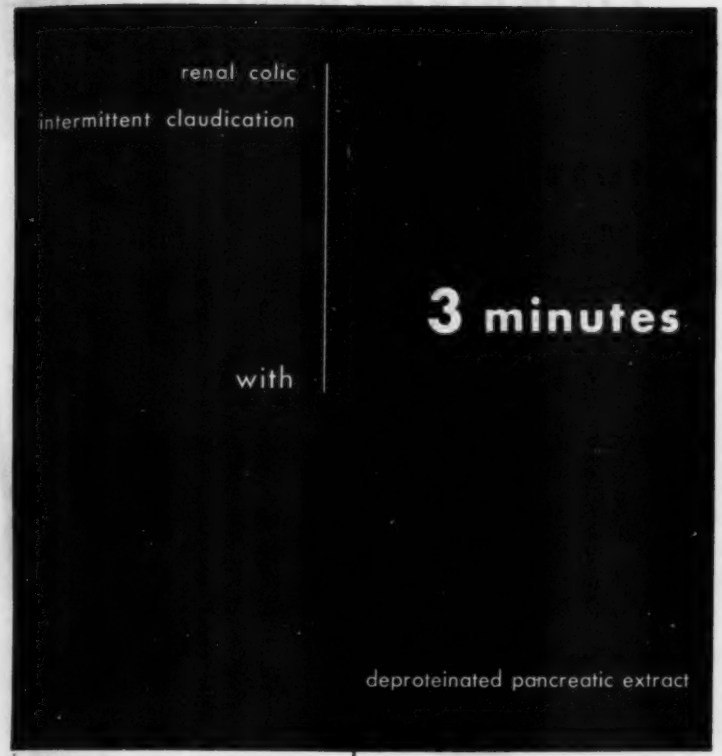

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This safe, effective antispasmodic is particularly useful in controlling spasm caused by calculus, stricture or instrumentation. Moreover, it is effective also in facilitating retrograde pyelography and ureteral dilatation, for treatment of spastic ureteritis, and for relief of primary dysmenorrhea.

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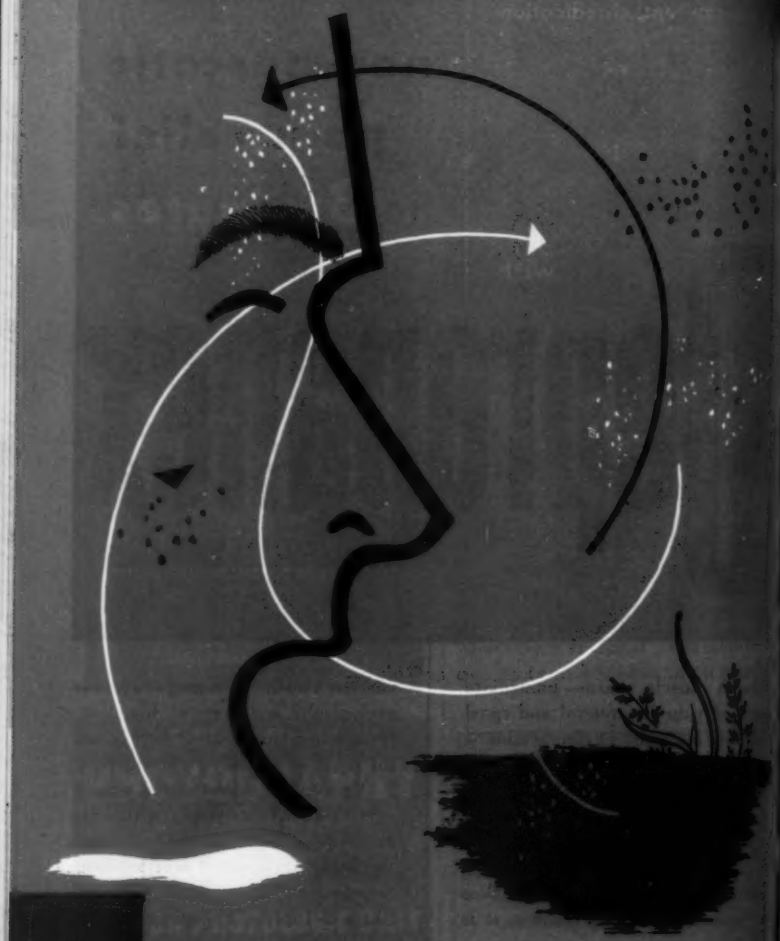
Less than 10% Reactions



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Gives your patients effective relief with fewer side effects

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75% to 85% of patients relieved (hay fever, allergic rhinitis, urticaria and itching dermatoses) in extensive clinical investigations.[1,2,3,4]

PATIENT PREFERENCE

Of 48 patients in one clinical study[1] who had previously taken other antihistaminics, 43 (90%) elected to continue on DECAPRYN therapy.

FEWER REACTIONS

DECAPRYN Succinate, with a milligram potency 2 to 4 times stronger than other histamine antagonists, produces an effective clinical response with correspondingly lower dosages . . . dosages that are well below the "toxic threshold" of the majority of patients. Brown[1] reports that side effects, such as drowsiness, occur in "probably less than 10% of the cases" at the effective dosage level—and are seldom severe enough to require even temporary withdrawal of medication.

DOSAGE

One-half to one tablet (12.5 to 25 mg.) 2 to 4 times daily, depending on the individual. Clinical studies show maximum benefits obtained with minimum effective dosage. Higher dosages of Decapryn are unnecessary and increase the possibility of drowsiness and other reactions.

LONGER DURATION

Feinberg[2] reports "longer action as compared to other antihistaminic drugs," while Sheldon[3] found that "symptoms were relieved from 4 to 24 hours after a single dose of Decapryn—which is a more lasting effect than that reported for other antihistaminic compounds."

1. Brown, E. A., Weiss, L. R., and Maher, J. P.: The clinical evaluation of a new histamine antagonist "Decapryn," Annals of Allergy. 6:1-6 (1948).
2. Feinberg, S. M., and Bernstein, T. B.: Histamine Antagonists. X. A new antihistaminic drug (Decapryn), J. Lab. & Clin. Med. 33:319-324(1948)
3. Sheldon, J. M., Weller, K. E., Haley, R. R., and Fulton, J. K.: Clinical observations with Decapryn, a new antihistaminic compound, Univ. Mich. Hosp. Bull. 14:13-15 (1948).
4. MacQuiddy, E. L.: Personal communication.

Decapryn (brand of Doxylamine) Succinate—25 mg. scored tablets—available at prescription pharmacies in 100's and 1000's

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CINCINNATI, U. S. A.

MERRELL 1828

the country. Under Montefiore's pioneer plan, selected cancer sufferers and other incurables are released from the hospital and given special attention in the home by staff doctors, nurses, physical therapists, and the like.

The program was started as a partial solution to the bed shortage. But, says its director, Dr. Martin Cherkasky: "Patients who in hospital surroundings lost all desire to live, and for whom we anticipated a downhill course, responded remarkably well upon return to the home and individualized care."

Cost of the program has averaged $2.25 per patient per day, as opposed to hospital bed costs of $12 per patient per day.

Video Will Instruct Conventioneers

Newly developed television techniques will be on display when the AMA meets in Chicago this month. RCA is setting up special theatre-type equipment at the Northwestern University Medical School, the Navy Pier, and the Hotel Sheraton. Audiences of 400-600 doctors will see technical telecasts covering surgery, gynecology, obstetrics, urology, dermatology, neurology, and internal medicine.

Would Exempt Savings From Income Tax

The doctor or other professional man finds it almost impossible, under our present tax system, to set aside enough money during his peak years to provide for future security. This opinion is advanced by the bar association of New York, which wants the law changed. It points out that the business man, by various legal devices, is able to provide for the future, but that the doctor is not.

The association recommends enactment of the so-called Silverson Plan. "Under that plan," it says, "every person with earned income (whether partner, self-employed, or employe) would be permitted to set aside his own fund for old age. This he would do by purchasing from current earned income a limited amount of non-negotiable government bonds, the cost of which would be excluded from his income

to revive normal interest and activity

'Dexedrine' is of unequalled value for the depressed patient.

Not only does Dexedrine produce striking improvement in mood and outlook—but, because of the unique "smoothness" of its action, it spares the patient the disturbing consciousness of "drug stimulation".

Smith, Kline & French Laboratories, Philadelphia

Dexedrine*

Sulfate elixir tablets

the central nervous stimulant of choice (*dextro-amphetamine sulfate, S.K.F.*)

*T.M. REG. U.S. PAT. OFF.

for tax purposes. The suggested limit is 15 per cent of earned income or $10,000, whichever is less. In later years, when he cashes any of the bonds, the proceeds thereof would become taxable as income in the year in which cashed."

Delay in Endorsing WHO Stirs M.D.'s

If the World Health Organization was not a dead duck a month ago, it was a mighty sick one. What it needed was a prescription marked "U.S. endorsement" and, even more, a transfusion of U.S. dollars. It looked as though WHO would get neither. Russia had just become the twenty-fourth nation to ratify its charter (twenty-six ratifications are required for a permanent organization). But the House Rules Committee, which had shelved a bill proposing U.S. ratification, apparently felt that any joint action with Russia was a waste of money and effort. One Congressman said: "This is the only special agency of the United Nations that seems to interest the Soviets. There must be a gimmick in it somewhere."

The Rules Committee's action was labeled "tyranny" by the Washington Post, which added: "The promotion of health is an obvious concomitant of the Marshall Plan. This country can scarcely be indifferent to the spread of disease among peoples it is assisting financially."

Said Dr. George Baehr, president of the New York Academy of Medicine: "This action, so portentous for the health and happiness of our own people, was taken behind closed doors and without public explanation [and against] the advice of the American Public Health Association and of all American experts in public health."

Parents Warned About Bloody 'Comics'

The anguished father sobbed openly before the reporters. "Comic books caused this," he said. "My boy was normal, happy. I hope I never see a comic book again."

A short time before, the father had found the body of his 11-year-old son hanging in their New York home. At the boy's feet lay an open comic book depicting a lynching. The self-hanging was a gruesome postscript to the warning of psychiatrists that the modern comic book is moral poison for children.

A few weeks earlier, Gershon Legman, who had made an exhaustive study of the comics, presented some facts about them to the American Association for the Advance-

Ideal For The Toddlers In Your Care—

Heinz Vegetables With Lamb And Liver

A Tasty and Nutritious Blend of Lamb, Chicken and Lamb Livers, Milk and Selected Vegetables

This appealing combination of meat, vegetables and milk—Heinz Vegetables with Lamb and Liver—makes a well-balanced main dish for the older babies in your care! It's mildly seasoned—and chopped to a particle size that promotes baby's easy chewing! You can recommend all Heinz Junior Foods confidently. They're backed by a 79-year quality reputation!

Toddlers also enjoy the other Heinz Junior Foods—such as Chopped Spinach, Pineapple Rice Pudding and Creamed Diced Vegetables!

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VEGETABLES
WITH
LAMB & LIVER
57 VARIETIES
MADE BY
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A 79-Year Reputa on Backs the Complete Line of

Heinz Baby Foods

CEREALS • FRUITS • VEGETABLES
MEAT FOOD PRODUCTS • DESSERTS

ment of Psychotherapy:

About half-a-billion copies of comic books are printed each year, two-thirds of them devoted to crime. Violence abounds on almost every page of the shockers, of which the average city child reads about a dozen a month. Figuring one scene of violence to a page, Mr. Legman estimates that the average child digests "300 scenes of beating, shooting, strangling, torture, and blood a month."

Calls Non-Participation 'Only Answer'

Non-participation is the physician's only answer to compulsory sickness insurance, for it is impossible to work with bureaucrats. This is the conclusion of Dr. Anthony B. Diepenbrock, former president of the San Francisco County Medical Society. He bases it on a ten-year experience with the Health Service System of that city.

"We San Francisco doctors are, I believe, experts in socialized medicine," Doctor Diepenbrock recently told the Mississippi Valley Editors Association. "We have had saddled upon us for a ten year period the only system of compulsory, socialized, governmental medical service which has existed in the United States. We accept this system as a medical care experiment in 1937 very reluctantly because of our lack of organization and political inability to cope with it. Under the system, municipal employes

DU PONT ANNOUNCES

The new "Patterson"

HI-SPEED SERIES 2 COMBINATION INTENSIFYING SCREEN

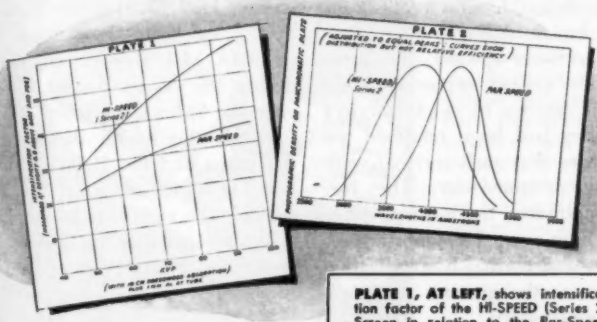


PLATE 1, AT LEFT, shows intensification factor of the HI-SPEED (Series 2) Screen in relation to the Par-Speed Screen. **PLATE 2, AT RIGHT,** indicates distribution of fluorescence of the new screen is from 2800 to 4000 Angstroms. Note maximum response occurs below the visible at 3800.

Here is a new Intensifying Screen that meets the long-felt need for greater speed *without loss of detail.*

Incorporating an entirely new luminescent chemical, the HI-SPEED (Series 2) Intensifying Screen offers several significant advantages to radiologists. It permits shorter exposures, thus minimizing the effect in the radiograph of involuntary action, bodily function, or movement by an uncooperative patient. It also enlarges the scope of low-voltage equipment such as the portable type.

With the new HI-SPEED Screen, an exposure of only 100 MAS will give the same radiographic results as an exposure of 150 MAS at 70 KVP with the Par-Speed Screen.

Write for complete literature about this valuable contribution to the science of radiology. E. I. du Pont de Nemours & Co. (Inc.), "Patterson" Screen Division, Towanda, Pa.

Listen to "CAVALCADE OF AMERICA"—*Monday evenings—NBC*

DU PONT
BETTER THINGS FOR BETTER LIVING THROUGH CHEMISTRY

"Patterson" Screens
The Standard of Screen Quality

were required to have deducted from their paychecks a monthly stipend for their medical care. The fund thus accumulating was administered by a board of nine city employes.

"These persons, needless to say, were unfamiliar with medical practices, insurance principles, and administrative procedures. In order for the system to maintain financial solvency, it became necessary to pay physicians' fees on a unit basis, which had a sliding value downward but never upward. The directors of the system empowered their medical director to delete services after they had been rendered, on the theory that such services were excessive or unnecessary. They further empowered the medical director to limit normal diagnostic procedures and normal hospitalization benefits on the grounds that such were unnecessary.

"Finally, the medical director appealed to the membership to resort to home remedies. The doctors patiently supported the system until the director made the above demands, which in effect made it impossible to give first-class medical service to the beneficiaries of the system.

"It is my sincere hope that if a similar situation, national or statewide, should develop, it will not take doctors ten years of futility and frustration to conclude that such systems can never be anything but dismal failures."

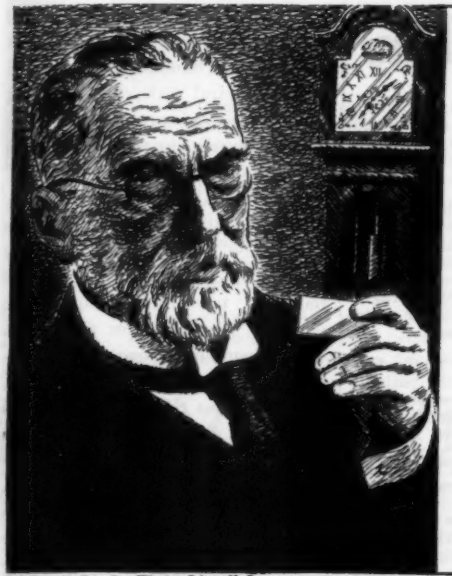
Says Socializers Use Health as Weapon

America is being led into socialism and its doctors into perpetual bondage by the Pan American Union and by the International Labour Organisation, charges Marjorie Shearon, PH.D., legislative consultant and publicist. Mrs. Shearon asserts that during the recent Bogota Conference the State Department blindly followed the health directives of the union and the ILO, which invariably based them on "workers' rights." The rights of the employer or professional man are ignored, she continues, in the general aim of regimentation.

"It is one thing," says Mrs. Shearon, "for an international organization interested in working conditions, hours of labor, factory regulations, and the like to develop international standards. It is something totally different . . . to invade the private lives of these workers and the rest of the population.

"The medical and many other professions cannot be standardized. Their members cannot follow the work habits of factory employes

Experience is the Best Teacher



Paul Ehrlich
(1854-1915)
proved it in chemotherapy

Paul Ehrlich concluded from experiences in the staining of bacteria that there was a close chemical affinity between the cellular body and the stain. This idea led him to believe that specific drugs could be found which would kill invading pathologic organisms, without damage to the host. His conclusions helped create the science of chemotherapy.

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Yes! Experience counts. And with thousands of smokers who have tried and compared many different brands of cigarettes, Camels are the "choice of experience."

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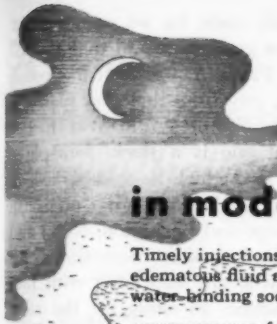
Three independent research organizations in a nationwide survey asked 113,597 doctors to name the cigarette they smoked. More doctors named Camel than any other brand.

without destroying the intangible qualities of mind which make possible the priceless achievements of scientific research and clinical medicine. But the juridical committee [of the Pan American Union] had no compunctions whatever about proposing to hamstring the medical profession and, indeed, to destroy it as a profession while at the same time jealously guarding—and even guaranteeing—the rights of labor."

Although Dr. Charles G. Fenwick, sole American member of the committee, protested strongly against its Charter of Social Guarantees, he nevertheless signed the charter, Mrs. Shearon points out. The document states: "Every person has the right to social security. The state has the duty to assist all persons to attain social security. To this end the state must . . . establish systems of social insurance . . . in accordance with which all persons may be assured an adequate standard of living and may be protected against the contingencies of unemployment, accident, disability, ill health, and old age."

Economy Impels M.D.'s To Quit V.A.

Congress' niggardliness with funds is scaring badly needed young doctors away from V.A. service, complains Dr. Paul Magnuson, chief medical director of the V.A. A month ago he reportedly had a showdown with Veterans Administrator Carl R. Gray, declaring that he was "damned mad" about the



Time and tide

in modern diuretic therapy

Timely injections of MERCUHYDRIN combat the rising tides of edematous fluid and check recurrences by mobilizing water-binding sodium[1] and stimulating its urinary excretion.

MERCUHYDRIN facilitates the recommended frequent-dosage schedules[2] of modern diuretic therapy. Convenience, high local tolerance[3, 4, 5] and increased safety of the intramuscular route[6] foster the maintenance of a relatively constant level of body fluid by repeated injections,[7] thus sparing patients the distressing consequences of intermittent massive diuresis.

Prompt inauguration of MERCUHYDRIN diuresis in cardiac patients exhibiting nocturnal dyspnea, orthopnea, pulmonary râles, cardiac asthma and insomnia relieves discomfort and prolongs life.[8]

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well tolerated locally, a diuretic of choice

Administration prior to or concurrently with digitalization avoids driving the faltering heart against an accumulated fluid burden and prevents the overdigitalization which may occur when postponed diuretic therapy mobilizes previously administered cardioactive glycosides from edema fluid.[9]

DOSAGE: 1 cc. or 2 cc. intramuscularly or intravenously, given daily, or as indicated, until a weight plateau is attained. Subsequently the interval between injections is prolonged to determine the maximum period permitted to intervene between maintenance injections.

PACKAGING: MERCUHYDRIN (meralluride sodium) is available in 1 cc. and 2 cc. ampuls.

BIBLIOGRAPHY: 1. Reaser, P. B. and Burch, G. E.: Proc. Soc. Exper. Biol. & Med. 63:543, 1946. 2. Conferences on Therapy, New York State J. Med. 43:2306, 1943. 3. Finkelstein, M. B. and Smyth, C. J.: J. Michigan State Med. Soc. 45:1618, 1946. 4. Modell, W., Gold, H., Clarke, D. A.: J. Pharm. & Exper. Therap. 84:384, 1945. 5. Jezer, A. and Gross, H.: Med. Clin. North America, Sept. 1947, p. 1301. 6. Wexler, J. and Ellis, L. B.: Am. Heart J. 27:86, 1944. 7. Conferences on Therapy, New York State J. Med. 44:280, 1944; 46:62, 1946. 8. Donovan, M. A.: New York State J. Med. 45:1756 (Aug. 15) 1945. 9. Levine, S. A.: Clinical Heart Disease, 2nd ed., Philadelphia, W. B. Saunders, 1942, p. 334.

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dismissal of medical personnel in a recent economy-forced reorganization. Mr. Gray immediately sent word to all branch offices that such personnel must be rehired.

Faced with the problem of replacing the 1,250 doctors who are expected to leave the V.A. this month, Doctor Magnuson says he cannot offer a feeling of security to prospective recruits if the administration has none itself. "Congress must decide," he says, "how much they're going to give us for a year." It's impossible, he adds, to provide effective medical service "if we have our plans changed every month or two."

Pioneer Flying Doctor Still Up in the Air

One of the first flying doctors—a surgeon who made headlines in 1919 when he used a Curtiss Jenny to rush fifty-five miles to aid an injured man—is still flying. He thus belies the prediction made in the Stamford (Neb.) Star almost twenty years ago: "Our friend Doctor Brewster of Beaver City has bought an airplane, and there will probably soon be an opening for another good doctor in that town."

Dr. Frank A. Brewster has come a long way from that first plane, a rickety relic of World War I. His current one is a sleek, four-place cabin job, which he uses to ride a circuit of hospitals he owns in Holdrege and Lexington, Neb., and in Oberlin, Kan. Sometimes his sons, who are associated with him in practice, go along for the ride. So does his wife, who is a nurse. Only one accident has marred the family record: In 1920 one son was seriously injured while stunting in the Jenny.

Doctor Brewster gave up his horse and buggy in the early 1900's and took to the motorcycle, then known as the "fool-killer." He graduated to a one-cylinder car, then to a whole series of early autos. In 1919, working night and day during the influenza epidemic, he realized that most of his time was spent traveling from patient to patient. On the advice of a friend, an ex-war flyer, he purchased his first Jenny. That started the doctor on his twenty-nine-year stint of making professional calls via the airlanes.

It Permits of the Prolonged Administration . . . **REQUIRED FOR SUCCESS IN OBSTINATE CASES**

Tarbonis is widely prescribed in

Eczema
Psoriasis
Ringworm
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In 2¼ oz., 8 oz., 1 lb. and 6 lb. jars.

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When infection supervenes, SUL-TARBONIS combines the bactericidal properties of sulfathiazole (five per cent) with the virtues of Tarbonis.

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Tarbonis has solved this difficulty, without sacrifice of therapeutic efficacy. It presents an alcoholic extract of carefully selected crude tars (5 per cent) in a vanishing-type cream. Its active ingredient is so highly refined that it is completely nonirritant — it may be safely applied several times daily, as often as every two hours, and as long as required.

In addition, Tarbonis is assured of patient acceptance and cooperation. It is free from all tarry odor — leaves no trace upon the skin after application — is greaseless, nonstaining and nonsoiling, to skin as well as linen and clothing — requires no removal before reapplication.

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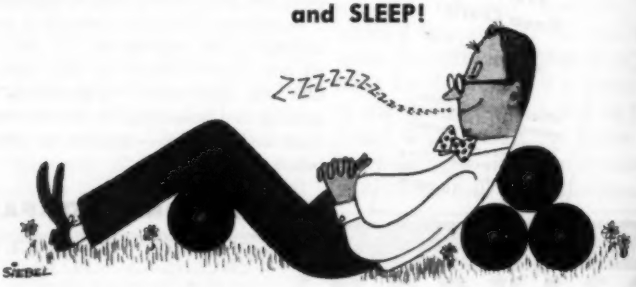
CAN DRINK DELICIOUS CAFFEIN-FREE **SANKA COFFEE and SLEEP!**



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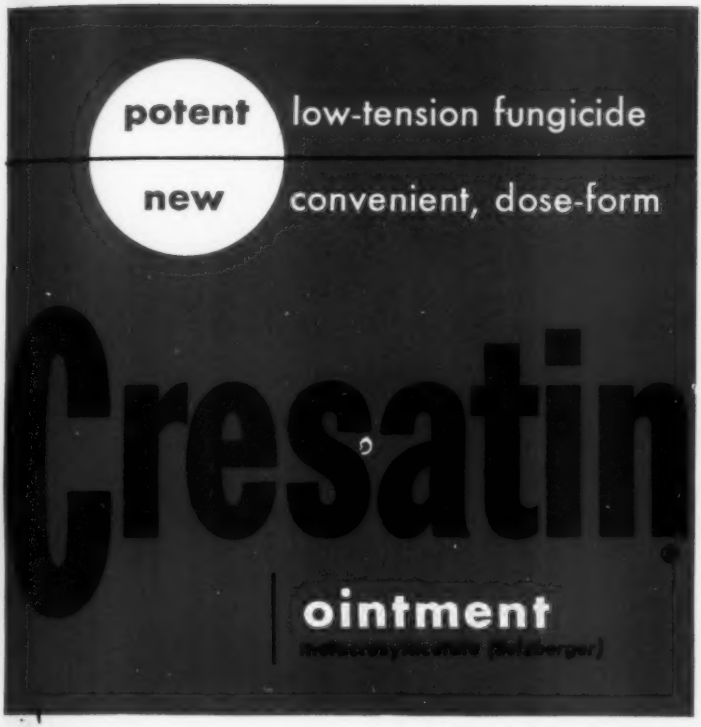

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